State Title V Block Grant Narrative

The following PDF was created from the most up-to-date electronic files available from the State for its Title V Maternal and Child Health Services Block Grant 1999 annual report and 2001 application. Some changes in fonts, formatting, page numbers, and image quality may have occurred during the conversion of the document to a PDF.

Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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1.4 Overview of the State

Restructuring of the health care financing and delivery system in Missouri is occurring at a rapid pace and will continue to evolve over a number of years. During this period of transition, some women, infants, children, adolescents and families will remain vulnerable. Although the rate at which women and children are being integrated within managed care plans such as MC+ and MC+ *for Kids* is accelerating, there will continue to be large pockets of high risk MCH population groups that no managed care organization (MCO) is willing to absorb because of their financial risk and/or geographic location. Many of these population groups require "population based" interventions outside of MCO delivery networks. Section 3.2.1 details Missouri's current MCH priority need areas. Criteria used to help determine the " importance, magnitude, value and priority of competing factors upon the environment of health services delivery" to MCH populations in Missouri, can be summarized as follows:

- **Criterion 1 – Degree to which need can be impacted by known effective interventions**
- **Criterion 2 – Degree of health-related consequence(s) of not addressing need**
- **Criterion 3 – Degree of state and national support other than Title V for impacting need**
- **Criterion 4 – Degree of current demographic disparity regarding need (e.g. race, gender, income, place of residence)**
- **Criterion 5 – Degree to which other local providers or service consumers identify need as a high MCH priority**

The Missouri Title V agency has taken the lead or is collaborating with other state agencies to support several important MCH related initiatives:

Office of Women's Health: Title V funding supports the newly-established Office on Women's Health, in the Department Director's Office. The new office is responsible for policy development promoting statewide coordination and collaboration among the many programs and services for girls and women.

Home Visitation: The Division of Maternal, Child and Family Health (MCFH), has recently taken the lead in working with the Governor's Office and the Children's Trust Fund in the formation of the *Home Visitation Interagency Council.* This council will

research existing home visitation programs, and pinpoint areas of overlap to more efficiently utilize state resources for home visitation programs. Title V funds are providing some support for different home visitation models and sites (including the Olds model) which will be compared and evaluated for greatest positive impact upon MCH outcomes.

State Children's Health Insurance Program: Collaboration continues with the Department of Social Services (Division of Medical Services) to identify and enroll children in the *State Children's Health Insurance Program* (SCHIP). Service coordination staff assigned to the Bureau of Special Health Care Needs, and local public health agencies also receiving Title V support, have worked with the Department of Social Services, other state agencies and local communities to help enroll over 55,000 children in Missouri's SCHIP initiative.

Pediatric Leadership Alliance: A Missouri team, sponsored by the Department of Health, was selected as one of 13 teams in the nation to participate in the Pediatric Leadership Alliance. The Pediatric Leadership Alliance is a joint project of the American Academy of Pediatrics and the Johnson and Johnson Pediatric Institute designed to enhance leadership skills of teams to frame projects promoting the health of children in communities. The mission of the Missouri Pediatric Leadership Alliance Team is to facilitate and support local partnerships to assure children in child care have access to medical homes, including medical, dental, and mental health services. The multi-professional team includes David Lohmeyer, M.D., pediatrician; Marcia Manter, health consultant to Head Start in Region VII; Debby Howland, director of an agency serving children who have been abused or neglected; Kathy Penfold, R.N., MCH Nurse Consultant for DOH; and Joy Oesterly, staff support in the Office of Planning and Evaluation. Embracing shared outcomes for Healthy Child Care America and MCH, the Missouri Pediatric Leadership Team plans to select a number of pilot sites using Head Start, Local Health Agencies, community child care providers and health care providers as the hub for creating community action. Attempts to address medical homes and access to health care issues are fragmented; this project will assist communities in working collaboratively to assure medical homes for children in child care.

Quality Assurance: The Department of Health (DOH) actively participates on the Missouri Medicaid Managed Care Quality Assessment and Improvement Advisory Committee (QA & I). This committee and the sub-group staffed by the Division of Maternal, Child and Family Health advises the state Medicaid agency on: the adoption of appropriate measurable population based quality indicators; health policy that improves

the health status of Medicaid managed care clients; adjustments to the cost of health care while maintaining or improving the quality of care; and the identification of "best practices" of MCH care. The Department of Health and the state Medicaid agency also collaborate on the exchange of program data to monitor quality indicators.

Medicaid Managed Care: Qualified women and children residing in the eastern, central and western regions of Missouri including the cities of St. Louis, Kansas City and Columbia continue to be served by Medicaid Managed Care. The recipients covered under managed care include families receiving cash assistance, pregnant women, children eligible for Medicaid, refugees, and children in state custody. Medicaid recipients in these groups who also receive SSI have the option to enroll in managed care or stay in the fee for service system. Expansion of Medicaid managed care plans will occur in Lincoln, St. Francois, St. Genevieve, Warren and Washington Counties. Medicaid will award contracts to MCOs in these areas by September 2000 with services beginning by December 2000.

Expanding Access to Dental Health Care: Considerable collaboration and facilitation has taken place between the Bureau of Dental Health and the Medicaid program specifically, and with other organizations and agencies that are actively involved in the lack of access to oral health care for Medicaid recipients issue. Additionally, the Bureau of Dental Health used some MCH Block Grant funding to expand dental health delivery capacity to better serve low income populations in Missouri. This one-time allocation of funding was utilized to create or expand existing dental health delivery capacity at ten local project sites.

Infant Mortality Workgroup: Under the direction of Dr. Maureen Dempsey, the director of the Missouri Department of Health, the Infant Mortality Workgroup continues to evaluate interventions to reduce infant mortality in Missouri. This workgroup consists of prominent neonatologists and obstetricians throughout Missouri. The workgroup is chaired by Dr. Sessions Cole and is charged with developing feasible, sustainable program interventions that address issues of prematurity, very low birth weight, and ultimately, infant mortality in Missouri. Two sub-groups have been formed to help better focus resources to improve the statewide capability to collect information, analyze data and to support specific interventions aimed at further reducing infant mortality in Missouri:

(1) *Infant Mortality Information Systems Sub-Group*

- Assists in the design and development of a low birth weight registry

- Assists in the enhancement of electronic birth certificate
- Assists in the development of statewide information systems to track infant mortality trends and outcome

(2) *Community Interventions Sub-Group*

- Benchmarks community based interventions in other states and countries
- Evaluates and prioritizes community-based interventions with the greatest potential to reduce infant mortality in Missouri
- Develops proposals for resources and funding to support demonstration of priority interventions at selected sites in Missouri

Governor's Conference on Health: The Governor's First Conference on Health: *Children, Missouri's Most Valuable Resource,* was held on July 12-14, 1999 in St. Louis, Missouri. This conference was planned and coordinated by the MCFH Office of Planning and Evaluation and the DOH Office of Public Information. Over 200 persons attended this conference which focused on children's health issues in the new millennium. Remarks and presentations by Governor Carnahan, the DOH Department Director, and other speakers were well received and will help the MCFH division better target Title V resources to serve MCH populations in Missouri.

Special Health Care Needs Initiatives: The Bureau of Special Health Care Needs (BSHCN) continues to participate in collaborative efforts through presentations to advocacy groups, contacts with providers, and participation on numerous councils and committees. These include but are not limited to: State Part C Interagency Coordinating Council, Local Interagency Coordinating Councils, SSI Interagency Coordinating Council, Practical Parenting Partnership, Head Injury Advisory Council, Pediatric Task Force, Missouri Partnership for Leadership Training Council, Council for Inclusive Child Care, and Occupational Therapy State Partnership. BSHCN collaborates with the Division of Medical Services (Department of Social Services) and Medicaid Managed Care plans to support mutual training. BSHCN staff continue to provide administrative case management and work with MC+ health plan(s) case managers to assure children with special needs receive necessary services through these plans. The Bureau of Special Health Care Needs, continues to coordinate its SCHIP enrollment efforts with the Department of Social Services (Division of Medical Services) and is part of a special task force initiated by The Department of Elementary and Secondary Education to redesign the Part C early intervention program called First Steps Program in Missouri. In FY99, the Bureau of Special Health Care Needs and the Bureau of Nutrition Services

designed a survey tool to help assess and enhance nutritional services needed by children with special health care needs.

Family Health Initiatives: The Bureau of Family Health maintains an interagency collaborative agreement with the Missouri Department of Social Services, Division of Medical Services, for well-child outreach and prenatal case management services. Well-child outreach is a statewide program emphasizing screenings for the child and adolescent populations, and encourages at-risk pregnant women to obtain early and regular prenatal care. The prenatal case management program focuses on quality assurance standards, technical assistance and coordination, and data management of the case management services with particular attention to standardizing risk appraisal processes.

Any overview of the MCH health care delivery environment in Missouri, quickly reveals glaring disparities between African-Americans and all other race/ethic groups for virtually every MCH indicator. Preterm birth is most prevalent among African-Americans, while the African-American low birth weight rate (LBW) is about double the rate for most other groups. The overall infant death rate among African-Americans exceeds that of any other group. Pregnancies of African-American women are more than twice as likely to end in fetal death than those of any other group. In Missouri, Hispanic births and births to non-Hispanic whites have comparable outcome rates. Asian/Pacific Islander births have a higher preterm and LBW rates, but lower infant and fetal death rates than non-Hispanic whites. These disparities can be correlated with level of income, education, and geographic location which create “unique challenges for delivery of Title V services” in Missouri.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

The State of Missouri statutes that relate to MCH and Children with Special Health Care Needs (CSHCN) authority are primarily found in Chapter 191 – Health and Welfare and Chapter 201 – Crippled Children (CSHCN) of the Missouri Revised Statutes. Changes or updates relating to MCH authority are:

HB 191 was passed by the 90th session of the General Assembly for implementation January 1, 2000. The bill requires the Missouri Department of Health to make available to physicians, hospitals, and clinics performing breast implantation a

standardized written summary that contains general information on breast implantation and discloses potential dangers and side effects of a breast implantation. Physicians are required to:

- Give the standardized written summary to the patient at least five (5) days before the breast implantation operation.
- Obtain the patient's signature on the form provided by DOH acknowledging receipt of the summary.

On December 13, 1999, DOH sent 846 letters to all hospitals, ambulatory surgical centers, and surgeons who perform or potentially may perform breast implementation. As of March 2000 the Bureau of Family Health has distributed 4,200 FDA patient booklets for the agencies/surgeons to use. The FDA is planning to update the booklet during the spring/summer of 2000 for distribution to providers as soon as it is available.

SB 445 and HB 401 mandates that by January 1, 2002, every newborn in Missouri will have their hearing screened. Information obtained from the screens, re-screens and referrals for services provided by Part C of the Individuals with Disabilities Education Act (IDEA) are to be reported to the Department of Health. The Department of Health is to collect data from the hospitals who will be providing screens by 2002; develop a surveillance system; establish standards and procedures; provide audiology and administrative technical support to facilities; provide written information on newborn hearing screening; and establish and staff a Newborn Hearing Screening Advisory Committee.

1.5.1.1 Organizational Structure

Within the Department of Health, the Division of Maternal, Child and Family Health (MCFH) is the state agency responsible for the preparation of the MCH Block Grant annual plan and application. The Director of the Division of Maternal, Child and Family Health serves as the director of the state's Title V program as well as director of the state's Children with Special Health Care Needs program. The Division has direct responsibility for designing and implementing programs to meet the needs of Title V target populations. Organizational charts for both the Department of Health and the Division of Maternal, Child and Family Health are included with this submission (Figures 1 and 2). The organizational system is further described in Sections 1.5.1.2 and 1.5.1.3.

Early in FFY99 the Missouri Department of Health reorganized, creating a new Division of Nutritional Health and Services. The new division encompasses programs in

the Bureaus of Nutritional Services and WIC and Nutrition and Child Care Programs. Both bureaus were formerly in the Division of Maternal, Child and Family Health. Within the Bureau of Nutrition and Child Care Programs, additional reorganization has also taken place. The Child Care Programs consisting of Child Care Resource and Referral, Child Care inclusion initiatives, Child Care Training and Professional Development, and Child Care Health Consultation were transferred to the Division of Health Standards and Licensure, Bureau of Child Care. Programs remaining in the Bureau of Nutrition and Child Care include the Child and Adult Care Food Program, the Summer Food Service Program, the Nutrition Education and Training Program, and the Missouri Nutrition Network. The reorganization that began in FFY99, is now essentially complete.

As part of the Department's reorganization, the Division of Maternal, Child and Family Health streamlined its operations to more effectively serve women, infants, children and adolescents in Missouri. The realigned MCFH division now consists of the Bureaus of Disabilities Prevention and Injury Control; Special Health Care Needs; Family Health; Dental Health; and the Office of Planning and Evaluation. MCFH Quality Improvement initiatives are now being supported through a contract with the University of Missouri Columbia Sinclair School of Nursing.

The mission of the reorganized MCFH division remains the same. That mission is to provide leadership to assure the health and well-being of all women of reproductive age, children and youth, including those with special health care needs, and their families. The division is responsible for developing policy; planning systems of care; and designing, implementing and evaluating programs to meet the health care needs of families in the state of Missouri. The reorganized MCFH division will also continue to be responsible for coordination of a range of functions aimed at facilitating the integration of selected maternal and child health programs and support functions into mainstream health plans and community delivery networks.

Office of the MCFH Director: Glenda Miller, M.P.H., B.S.N, C.S, is the Director of the Division of Maternal, Child and Family Health (MCFH). She has a diverse background including experience as a former Assistant District Administrator in the Southwest District; Community Health Nursing Consultant; Program Coordinator with the Bureau of Special Health Care Needs; emergency room triage nurse and experience as an Assistant Professor with Southeast Missouri State University. More recently, Ms. Miller was a Special Programs Manager with Cox Freeman Health Management Services, providing her with experience in the managed care arena.

Tricia Schlechte, M.P.H., B.S.N, is the Deputy Division Director of MCFH and also brings a diverse background to the Department, including experience as the Managed Care Coordinator with the Center for Local Public Health Services; Community Health Nursing Consultant; Quality Assurance Coordinator; Health Educator; Wellness Program Manager; Field Services Coordinator with the Group Health Cooperative of Puget Sound; and experience as a Public Health Nurse and Charge Nurse.

Deborah Goldammer, M.A., M.P.A., the Assistant to the Division Director, provides fiscal and budgetary expertise for MCFH and oversees the Fiscal Services Support Unit (FSSU). This unit processes invoices and contract payments for various bureaus within the division. Ms. Goldammer has served both the legislative and executive branches of Missouri State Government in various capacities since 1976.

There are four bureaus, and one office which serve as the principal operating components for block grant-funded programs. They are:

Bureau of Family Health: The Bureau of Family Health (BFH) has primary responsibility for developing and implementing programs that include infant mortality reduction, effective family planning services, child and adolescent health services, and school linked health services to school-age children. These services are provided under the direction of Paula F. Nickelson, M.Ed.,Chief of the bureau. Mrs. Nickelson has a distinguished career of over twenty years in the human services and management fields with multiple business and professional affiliations. Her broad base of experience consists of all facets of management including fiscal, personnel, business and program development, contract procurement, public relations and marketing. Mrs. Nickelson directs the BFH in developing and monitoring contracts with local public health agencies, private providers, school districts, community health centers, and other agencies for the provision of services. Further BFH responsibility includes outreach and education to high-risk adolescents, and providing services to rape victims through contracts with crisis centers located across the state.

Bureau of Special Health Care Needs: The Bureau of Special Health Care Needs (BSHCN) focuses on early identification of children with special health care needs; providing service coordination for children and families; and funding for preventive, diagnostic and treatment services;. Service coordination is provided by staff located in ten regional offices throughout the state. The Children with Special Health Care Needs Program, Head Injury Program and genetic programs administered by the bureau are supported through a community-based, family-centered approach. Richard L.

Brown, M.H.A., Ph.D., FACHE, provides leadership to the BSHCN. Dr. Brown, a graduate of the University of Missouri, St. Louis University and Florida State University, has over 26 years of management and academic experience in the field of public health, in both the public and private sectors.

Disabilities Prevention and Injury Control: The Bureau of Disabilities Prevention and Injury Control (BDPIC) coordinates and expands prevention activities in Missouri to reduce the incidence of primary and secondary disability associated with birth, development, disease and injury. The bureau conducts public, professional and patient education advocacy; surveillance; needs assessment; resource identification and/or development; and collaboration and coordination with other public and private entities. This bureau is under the interim direction of Jim Jeffries, M.P.A. Mr. Jeffries received his undergraduate degree in Business Administration from Drury University and he obtained his Master in Public Administration degree from the University of Missouri, Columbia, in 1990. During his employment with the Missouri Department of Health, he has served as the Chief of the Bureau of Perinatal and Child Health (now the Bureau of Family Health) and as a Management Analysis Specialist for the MCFH division. He is also a former teacher having taught over eight years at the middle and high school levels.

Bureau of Dental Health: The Bureau of Dental Health (BDH) administers a statewide community water fluoridation program. This initiative provides equipment for new installations and replacement equipment for those communities upgrading or replacing equipment. The bureau also administers a fluoride mouth rinse program in schools across the state at no cost to students. Dental sealants are provided at no cost to the students for second and seventh graders who meet income guidelines. This program is carried out in school-based settings, private dental offices and public clinics. The Bureau also provides information on proper dental care through coordination of activities with local health agencies, schools and child care. In addition to these programmatic initiatives, the bureau is involved in a broad range of activities to address oral health issues. These activities include, but are not limited to, a study of barriers to access to care conducted in 1998. The study was conducted to assist the Department of Social Services (DSS) in providing improved access to dental care for Medicaid recipients, to evaluate aspects of the Medicaid dental program in Missouri, and to develop a series of policy options for improving the program. The Bureau facilitated the use of the CDC Oral Health Module in the 1997 Missouri BRFS, and in 2000, the

children's oral health survey will be repeated. The Bureau of Dental Health is under the direction of M. Dean Perkins, D.D.S., M.P.H., who is a graduate of the University of Missouri (at Kansas City) School of Dentistry and the University of North Carolina School of Public Health. He brings over 11 years of public health experience to MCFH.

Office of Planning and Evaluation: The Office of Planning and Evaluation (OPE), supports departmental and interagency planning and evaluation to better achieve healthy outcomes for women, infants, children, adolescents and children with special health care needs. Specifically, these functions include: grants development and management (Title V Block Grant and SSDI Grant); program analysis and evaluation; statewide MCH need/capacity assessments; departmental strategic planning and interagency planning and evaluation. This office also provides ongoing staff support for the Healthy Missourians Sub-Cabinet for Show Me Results established by the Governor's office in 1999. OPE continues to serve as a liaison to the HRSA Maternal and Child Health Bureau to support a range of Title V activities. Finally, OPE provides guidance in developing many MCH related *New Decision Items* for Missouri Department of Health budget proposals. The Office of Planning and Evaluation is under the direction of Nick Boshard, M.P.H., Ph.D., who is a graduate of the University of Hawaii School of Public Health.

Office of Quality Improvement: The Division of MCFH has recently contracted with the University of Missouri's School of Nursing for assistance in the planning and support of QI initiatives. This CQI model has been well received and my obviate the need to establish a formal Office of Quality Improvement.

Other divisions and centers within the department continue to play vital roles in supporting a comprehensive set of services for target Title V populations in Missouri. This includes the Center for Health Information Management and Epidemiology (CHIME) which now works closely with MCFH to monitor Title V MCH outcomes, performance measures as well as recently announced health status indicators. The Divisions of Chronic Disease Prevention and Health Promotion; Administration; Health Standards and Licensure; Nutritional Health and Services; and the Centers for Local Public Health Services and Community Development and Health Care Access also play important roles in supporting target Title V populations in Missouri.

See Section 5.3, figure 2

1.5.1.2 Program Capacity

The Bureau of Family Health supports preventive and primary care services for pregnant women, mothers and infants primarily through family planning contracts which encourage women of child bearing age to seek adequate prenatal care. Preventive and primary services for children are supported by the BFH through grants to public schools, and local public health agencies that fund services for school aged children.

The Bureau of Special Health Care Needs also supports health services for children with special health needs and "provides and promotes (based upon income guidelines) family-centered, community-based, coordinated care for those children in Missouri." The Children with Special Health Care Needs Program provides early identification of children with special health care needs, birth to age 21, who meet financial eligibility (185 percent of poverty) and medical guidelines. The Bureau of Special Health Care Needs assists with diagnostic evaluation, service coordination and treatment services including medical care for sub specialty and specialty services, hospitalization and medical equipment for children. The following are some conditions which may meet medical need guidelines: arthritis, burns, heart defects, cerebral palsy, cleft lip or palate, cystic fibrosis, hearing loss, hemophilia, sinusitis, myelomeningocele, seizures, neuropathy, scoliosis, sickle cell, genitourinary disorders and disorders of the eye.

1.5.1.3 Other Capacity

The number and location of staff that work on Missouri Title V programs are listed on the following chart. This listing includes staff who provide planning, evaluation, and data analysis capabilities.

DIVISION OF MATERNAL, CHILD AND FAMILY HEALTH MCH PROGRAM STAFF

FFY2000

TITLES	LOCATION		FTE'S
ADMINISTRATION			
Division Director	Central Office		1.00
Deputy Director	Central Office		1.00
Assistant to the Director	Central Office		1.00
Management Analysis Specialist II	Central Office		1.00
Accounting Analyst III	Central Office		1.00
Designated Principal Assistant	Central Office		1.00
Clerk IV	Central Office		1.00
Clerk Typist III	Central Office		2.00
		Total	9.00

OFFICE OF PLANNING AND EVALUATION			
Program Manager	Central Office		1.00
Planner III	Central Office		1.00
Management Analysis Specialist II	Central Office		1.00
Clerk Typist III	Central Office		1.00
		Total	4.00
FISCAL SERVICES SUPPORT UNIT			
Executive I	Central Office		1.00
Clerk IV	Central Office		1.00
Account Clerk II	Central Office		1.00
Account Clerk II	Central Office		2.00
Clerk Typist II	Central Office		1.00
		Total	6.00
FAMILY HEALTH			
Program Administrator	Central Office		1.00
Asst. Health Program Admin	Central Office		2.00
Clerk IV	Central Office		1.00
Clerk Typist III	Central Office		2.00
Clerk Typist I	Central Office		6.00
Health Program Representative III	Central Office		4.00
Health Program Representative II	Central Office		5.00
Health Program Representative I	Central Office		1.00
Consultant Community Health Nurse	Central Office		5.00
Health Educator III	Central Office		1.00
Info Support Coord	Central Office		1.00
Management Analysis Specialist I	Central Office		1.00
Project Specialist	Central Office		1.00
Community Health Nurse V	Outstate		6.00
		Total	37.00
DENTAL HEATLH			
Health Program Admin	Central Office		1.00
Clerk IV	Central Office		1.00
Dentist III	Central Office		1.00
Health Program Representative III	Outstate		5.00
		Total	8.00
DISABILITIES PREVENTION AND INJURY CONTROL			
Program Administrator	Central Office		1.00
Clerk IV	Central Office		1.00
Health Program Representative III	Central Office		3.00
Health Program Representative I	Central Office		1.00
Clerk Typist III	Central Office		1.00
Clerk Typist II	Central Office		1.00
		Total	8.00
SPECIAL HEALTH CARE NEEDS			
Asst. Health Program Admin	Central Office (1), Outstate (3)		4.00
Consultant Community Health Nurse	Central Office		2.00
Community Health Nurse III	Outstate		27.00
Community Health Nurse IV	Outstate		1.00
Community Health Nurse V	Outstate		2.00
Clerk II	Central Office		3.50
Clerk IV	Central Office (2), Outstate (5)		7.00

Clerk Typist II	Outstate		19.50
Clerk Typist III	Central Office (4), Outstate (8)		12.00
Clinical Case Work Assistant I	Outstate		1.00
Coord. Of Children's Program	Central Office		1.00
Health Program Representative I	Central Office (1), Outstate (1)		2.00
Health Program Representative II	Central Office (1), Outstate (13.50)		14.50
Health Program Representative III	Central Office (2), Outstate (1)		3.00
Information Support Coord	Central Office		1.00
Lic Clin Soc Worker	Outstate		7.00
Management Analysis Specialist I	Central Office		1.00
Program Administrator	Central Office		1.00
Social Work Pract II	Outstate		3.00
Speech-Language Pathologist	Outstate		2.00
		Total	114.50
	TOTAL FTEs		186.50

Other staff in the Department also support the work of maternal and child health activities and services. The time accounting system used by the Department shows an equivalent of 46.70 FTEs outside of the Division of Maternal, Child and Family Health who worked on MCH related activities from April 1999 through March 2000. Most of the support came from the public health laboratory and the Office of Information Systems, and the Bureau of Child Care. These units contributed 89 percent of the external FTE support to the division.

In FFY 1999, the Bureau of Nutrition and Child Care Programs had management staff who are members of the Child Care Advisory Committee. The Child Care Advisory Committee informs and advises the Missouri Department of Health on child care issues and has one member who is the parent of a child with special needs. The Bureau of Child Care has management staff who are members of the Council for Inclusive Child Care and has coordination and facilitation responsibilities for the Council. The Council for Inclusive Care promotes the inclusion of all children in child care and provides guidance to the Department of Health, Social Services, Mental Health, and Elementary and Secondary Education about policy and program development for the care of children with special needs. Approximately ten of the task force members are parents of children with special needs.

1.5.2 State Agency Coordination

Other State Agencies: The Missouri Department of Health, Division of Maternal, Child and Family Health is a party to several written agreements or memoranda of

understanding with other state agencies that support collaborative efforts to serve Title V populations in Missouri. Interagency agreements with the Departments of Social Services (DSS), Elementary and Secondary Education (DESE), Mental Health (DMH), and Natural Resources (DNR) are discussed below:

- Agreements with the Medicaid agency address the broad rules and responsibilities of each agency to maximize and coordinate services for medically indigent individuals, including service coordination and case management services for Medicaid-eligible, at-risk pregnant women and children. The Bureau of Special Health Care Needs (BSHCN) coordinates perinatal substance abuse services with DSS, DMH and DESE. Formal interagency agreements also exist with the Department of Social Services for administrative case management activities for the Healthy Children and Youth (EPSDT) program for home visitation programs, and with the Department of Elementary and Secondary Education for service coordination of the First Steps program.
- The Bureau of Family Health (BFH) has cooperative programs with the Division of Social Services on the Prenatal Case Management (interagency agreement), and the Temporary Assistance During Pregnancy (TEMP) Program. In addition, the Bureau, mandated by state statute, cooperates with the Departments of Mental Health, Social Services, and Elementary and Secondary Education to implement the Perinatal Substance Abuse program. Finally, an agreement beginning in 1997 between DOH and the DMS to implement a state-wide program designed to promote the health of children, adolescents and pregnant women is currently in force. This agreement provides for special outreach efforts to promote prenatal care and to encourage well-child screening and checkups throughout the state, and is implemented as the *Well Child Outreach Project.*
- The Bureau of Family Health is collaborating with the Department of Corrections and the Missouri Coalition Against Sexual Assault (MoCASA) to sponsor a Sexual Exploitation Training Conference at sites in Kansas City and St. Louis in 2000. The target audience includes victim service providers, court advocates, counselors/therapists, law enforcement, prosecutors, social workers, health providers, probation and parole, child care providers and school personnel. The emphasis of the conference will be community safety and victim recovery, reduction of sexual violence and exploitation and multidisciplinary collaboration.

- The Bureau of Disabilities Prevention and Injury Control (BDPIC) coordinates a governor-appointed advisory group, the Missouri Genetic Disease Advisory Committee. The Missouri Genetic Disease Advisory Committee advises the Department in quality assurance of the delivery of services to Missouri residents with genetic conditions. The Committee has four sub-committees (Newborn Screening, Cystic Fibrosis, Hemophilia, and Sickle Cell Anemia). The advisory committees are comprised of representatives from the treatment centers, providers, physicians and consumers. BDPIC works in collaboration with BSHCN on activities related to the Cystic Fibrosis and Hemophilia Standing Committees. The Bureau of Disabilities Prevention and Injury Control also coordinates the Missouri Injury Control Advisory Committee which serves as a forum for addressing injury issues and provides guidance regarding injury prevention initiatives and activities conducted in the state. This committee is appointed by the Director of the Department of Health and has representation from state, local, public and private agencies, and professionals with injury expertise. BDPIC also serves as the lead agency for the Missouri SAFE KIDS Coalition and its six local coalitions in the state.
- The Bureau of Dental Health (BDH) has an interagency agreement with the Missouri Department of Natural Resources (DNR) to assist communities in fluoridating their water supplies. Under this agreement, the Department funds a state fluoridation engineer with DNR. The fluoridation engineer works with local officials to design fluoridation systems, consults with BDH professional staff on the selection and purchase of equipment, and assists with problems that may occur. In addition, the agreement funds staff from the DNR Public Drinking Water Program (PDWP) to inspect fluoridation equipment in water plants and to provide training and technical assistance for fluoridation supplies. PDWP staff also compiles data on required monthly testing of fluoride levels and provides the data to the Bureau of Dental Health. The Bureau of Dental Health also maintains informal working relationships with other outside agencies. BDH is the primary force behind the Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.) Coalition. P.A.N.D.A., a public-private coalition of dental organizations across Missouri, trains dentists and other health care, education and child care professionals in preventing family violence, including child abuse and neglect. Since P.A.N.D.A.'s inception in 1992, dentists' reporting of suspected child abuse and neglect has risen 160 percent. Another BDH collaborative effort is the Missouri Emergency Response Identification Team

(MERIT). MERIT is composed of more than 50 dentists and dental team members specially trained for forensic identification on the event of mass disaster. MERIT is co-sponsored by BDH, the Missouri Dental Association and the State Emergency Management Agency.

- In 1997, Missouri's Governor established the Commission on Management and Productivity (COMAP) to conduct a review of state government, evaluate its strengths and weaknesses, and prescribe reform. One of the COMAP recommendations was to develop a uniform strategic planning process for a statewide vision and strategic plan that integrates the long-range planning processes of individual agencies. As a part of the strategic planning process the Governor identified over twenty outcomes within five key areas of safety, health, economic prosperity, education and effective and efficient government. These outcomes are referred to as the *Show Me Results*:
  - The Governor formed five sub-cabinets to address various results within the five key areas. The Missouri Department of Health became the team leader for the Healthy Missourians Sub-Cabinet. Lead staff resources for the Sub-Cabinet have been drawn from The Division of Maternal, Child and Family Health and The Center for Information Management and Epidemiology. The Sub-Cabinet focused on three results: *increasing the percent of pregnancies resulting in healthy weight babies; decreasing the rate of infant mortality; and reducing the percentage of teenage pregnancies.* The Sub-Cabinet formed a research team to develop a report that identified current and projected performance, current strategies, performance measures and recommendations with an action plan. During FFY2000, Title V funds have helped support the implementation of those recommendations such as the creation of an interagency home visitation council. The Office of Planning and Evaluation serve as continuing staff support to the Show Me Results Sub-Cabinet on a range of maternal and child health issues.
  - Along with participation in the Show Me Results Sub-Cabinet, MCFH is also involved with the Caring Communities Program. Caring Communities is a Missouri governmental initiative begun in 1989, as a school based integrated services delivery system. The Missouri Department of Health is one of seven state agencies that form a cross agency structure to work together to implement broad based system(s) reform to improve the conditions of Missouri families. The seven state agencies, the departments of Corrections, Economic Development,

Elementary and Secondary Education, Health, Labor and Industrial Relations, Mental Health and Social Services, work in coordination with the Family Investment Trust and the Community Partnerships to shape priorities for children and families.

Federally Qualified Health Centers/Community Health Centers: No material Included.

Local Public Health Agencies: The Department of Health contracts with over 100 local public health agencies (LPHA) to promote and improve the health of families within their jurisdictional areas. These funds are to be used solely to benefit the residents of Missouri, especially women, infants, children, adolescents, and children with special health care needs. LPHAs use these funds to provide a broad range of community based primary prevention and early intervention services, emphasizing outreach and case management. Clients include their non-Medicaid population, and those with little or no health insurance coverage.

The Child Care Health and Safety Consultation Program is a statewide collaboration between the DOH and numerous local public health agencies (LPHA) in Missouri. LPHA health consultants provide health and safety consultation and training for child care providers in their respective communities. Various state and local public and private organizations are collaborative partners in the implementation of the Health and Safety Consultation program. This program is supported with blended funding from the federal Child Care and Development Fund, MCH Block Grant, and a Health Systems Development in Child Care grant which supports the “Healthy Child Care America” campaign goals.

The Missouri Department of Health was recently awarded a *Turning Point Grant* from the Robert Wood Johnson Foundation. To support the goals of this grant, the Office of Planning and Evaluation is working closely with The Center for Local Public Health and local public health partners to strengthen the public health infrastructure in Missouri by determining:

- Infrastructure changes required at model sites and at the state level to assure that the public health is protected and improved;
- Relationships necessary at the local and state level among public health, the private medical sector, other public agencies and the community at large to address public health needs;

- Funding levels, sources of funding and strategies for securing funding that will adequately support a model public health system;
- Local and state policy, ordinance and law changes needed to fulfill core public health responsibilities; and document the model public health infrastructure system so that it can be replicated in Missouri and throughout the nation.

Tertiary Care Centers/Regional Perinatal Centers: No material included.

Universities and Schools of Public Health: The Bureau of Disabilities Prevention and Injury Control (BDPIC) continues to collaborate with the University of Missouri-Columbia, and Washington University on the Disability Epidemiology and Health Project. This project develops data systems and links data sets to enhance surveillance capacities contributing to the understanding and prevention of secondary conditions, enhances referral networks and available resources and fosters health promotion among people with disabilities through statewide collaborations. A manuscript titled "The Missouri Disability and Health Project" was published in the Spring 1999 issue of the *American Journal of Preventive Medicine* describing the project as a model for public health and academic collaboration. Data about mobility impairments resulting from secondary conditions will be analyzed. Results from provider surveys to determine access to health care for individuals with disabilities will be used to develop educational interventions and inform state policymakers about issues related to disabilities. A disability work group composed of representatives from each university and the BDPIC meet monthly to provide recommendations to the Department on the project.

The BDPIC also contracts with Southwest Missouri State University to conduct the newborn hearing screening pilot project and to provide feedback to hospitals. The university provides consultation to hospitals developing a universal newborn hearing screening program and collaborates with the Universal Newborn Hearing Screening Task Force.

The Bureau of Nutrition Services and WIC also continues to provide public health experiences for dietetic students completing their internship or studies through Southern Illinois University in Carbondale and the University of Missouri-Columbia.

The Bureau of Family Health maintains a contract with the University of Missouri to provide medical consultation and administration of the Sexual Assault Forensic Evaluation-Child Abuse Resource and Education (SAFE-CARE) Network. The Network conducts training and update sessions for physicians and nurse practitioners that examine children to determine sexual abuse, physical abuse, or neglect. The medical

director and advisory council members provide medical consultation to members of the network.

The Department of Health provides a facilitated site for Partnerships for Preventing Violence, a six-part satellite training forum conducted by the Harvard School of Public Health. The final broadcast, *Bringing the Elements Together: Ending the Cycle of Violence,"* is scheduled for October 20, 2000.

The Bureau of Child Care, in the Division of Health Standards and Licensure, has established a partnership with the University of Missouri Kansas City (UMKC) Institute for Human Development to conduct a study of child care for children with special needs. Initial phases of a study to establish baseline data relative to current capacity of child care for children with special needs have been completed. This assessment is a three year project and methods of research include: focus groups with child care providers and families of children with special needs; written surveys with families and all regulated child care providers, including early intervention providers and telephone surveys with families and child care providers. UMKC will be forming a parent advisory Board to assist in interpreting the data and formulating recommendations for policy development and system changes.

The Missouri Partnership for Leadership Education project at the University of Missouri-Columbia Health Sciences Center is focused on training professionals, especially in rural areas, regarding the best strategies to serve children with special health care needs. Project LEND (Leadership and Education in Neuro-developmental Disabilities) was funded in 1998 for a five year period. The goals of the project include conducting a comprehensive program of interdisciplinary leadership training to enhance health care services to children with neuro-developmental and related disabilities; providing technical assistance to state and community agencies and groups including the state Title V agency on identified need areas; supporting information dissemination and research activities to enhance leadership training; and refining a model of rural health care delivery for children with neuro-developmental and related disorders. Staff from the BSHCN continue to participate on the advisory committee to this project. BSHCN works with the University to coordinate technical assistance and outreach training. In addition, BSHCN is exploring collaboratively developing a staff liaison to coordinate and link Title V CSHCN staff with Project Lend. This will help link students to professional careers in public health, facilitating the "latest advancements" in care

coordination activities for special health care needs clients, and fostering closer integration of academic and public health delivery systems.

The Division of Maternal, Child and Family Health is partnering with the University of Missouri to implement a birth defects grant awarded to the department in 1998. This includes the Spina Bifida Intervention Project which is aimed at reducing the incidence of Spina Bifida and other neural tube defects through prevention of recurrence. This initiative involves determining the level of understanding among target families regarding the use of folic acid to prevent recurrence; referral of selected families for genetic evaluation and counseling services; identification of infants with Spina Bifida; their level of disability; and provision of referral to the Bureau of Special Health Care Needs for service coordination and when appropriate, referral to early intervention and health services to lessen the impact of Spina Bifida on the infant's quality of life.

The Missouri Partnership for Enhanced Delivery of Services, facilitated through the Department of Physical Medicine and Rehabilitation of the University of Missouri has begun a three year project with funding assistance by the BSHCN. This partnership is developing a coordinated system of care for children with special health care needs in mid-Missouri. It will focus on family assistance in coordinating needed services by encouraging local partnerships with family, health care providers, schools and state agencies.

Other: In addition to the coordination efforts described above, the Missouri Title V agency coordinates and collaborates with various task forces, coalitions and networks related to all MCH populations.

Two Missouri organizations continue to receive Healthy Start grants. One is the Missouri Bootheel Healthy Start Project (MBHS) for five counties in the Southeast portion of the state, managed by SIDS Resources, Inc. The other grantee is the Kansas City Maternal Child Health Coalition, managed through the United Way. Goals for both projects include increasing community coordination and cooperation with a Regional Consortium and education for health providers, the public, and clients of the perinatal health care system. Selected objectives include reducing the percent of women who receive inadequate prenatal care, teen births, preventable accidents, smoking during pregnancy, and birth defects caused by teratogens. The MCFH division continues to coordinate with both grantees to avoid unnecessary duplication of services and collaborate with them by participating in various task forces and ad hoc activities to address needs and assist with outreach efforts.

In addition to the Healthy Start Grants, Missouri is in the final year of a federal TBI (traumatic brain injury) Demonstration Grant from the Health Resources and Services Administration. The purpose of the State Implementation Grant is to improve planning, coordination, collaboration and to achieve improved personal and family outcomes of increased independence, community inclusion/integration, productivity and satisfaction to individuals with traumatic brain injury (TBI). The project will demonstrate improved local linkages and program collaboration resulting in outcomes of: increased consumer and family satisfaction; community inclusion; independent living/housing; and competitive employment. Year one of the project focused upon on the Mid-Missouri region. Years two and three are replicating the project in St. Louis, Southeast Missouri, Kansas City, and Springfield. A range of strategies and activities have been used to achieve a planned, economical, comprehensive, and sensitive system of supports. Collaboration is occurring with the Departments of Health (Head Injury Services Program), Mental Health, Social Services, Elementary and Secondary Education, the Office of Administration, the Missouri Brain Injury Association, Services for Independent Living, Advent Enterprises, and Missouri Parents Act (MPACT), the University of Missouri-Columbia, Rusk Rehabilitation Center, Columbia Public School System, and the University of Missouri-Kansas City, Institute for Human Development.

The Bureau of Child Care coordinates the Council for Inclusive Child Care (CICC) that was formed in 1996. The purpose of the council is to promote and enhance the development of programs and systems throughout the state. These programs and systems support providers in offering quality, inclusive early care and education of children with special health care needs; and support parents in advocating for accessing quality early care and education. The CICC continues to bring together child care providers, family members of children with special needs, child care trainers, children's advocates, community child care leaders, state agencies, agencies that provide services to children with special needs, Part C-Early Intervention coordinators, Head Start, and others to develop and implement strategies that support the inclusion of children with special needs in child care.

Missouri is one of ten states to participate in the Map to Inclusive Child Care project funded by the federal Maternal and Child Health Bureau. The Bureau of Child Care continues to serve as the project liaison. Other team members include parents, child care providers, state agencies, child care resource and referral agencies, and a

legislator. This initiative is promoting the inclusion of children with special health care needs in all child care settings.

The Bureau of Child Care also seeks public input regarding child care through the Child Care Advisory Committee. Members of the advisory committee include parents and consumers of child care, child care providers, child care advocates, child care resource and referral centers, child care trainers, Head Start, community religious leadership, and others.

The Missouri Title V agency also coordinates with various federal departments, both directly and through federally funded coalitions. An example of direct coordination is the agreement between the State Disability Determination Unit of the Social Security Administration and BSHCN to refer children who apply for SSI to the CSHCN program. Referrals are sent directly to BSHCN area offices from the Disability Determination Unit (DDU).

As referenced earlier, the Department of Health is a member of the MC+ Quality Assessment and Improvement Advisory Group (MC+ QA & I). The group is a partnership of representatives for the major stakeholders in the Missouri Medicaid Managed Care Program. The group includes each health care plan participating in Medicaid managed care; the Missouri Consolidated Health Care Plan; the Missouri Patient Care Review Foundation; the Missouri Medicaid Drug Utilization Review Board; the Missouri Medicaid Consumer Advisory Group; the departments of Health; Mental Health; and Insurance; three practicing physicians; a practicing dentist and a representative from another health care profession; a representative from a local public health department; a representative from a hospital and a chair person chosen by Missouri Medicaid.

The MC+ QA & I Advisory group's mission is to adopt appropriate broad measurable population-based quality indicators; ensure quality care for Medicaid recipients; foster, support and enhance quality improvement programs of individual plans and provider groups; monitor process and outcomes; interpret data, recommend and prioritize areas for improvement activities; and provide a forum where concerns of the various stakeholders can be communicated thereby improving the health of Medicaid recipients. As referenced earlier in this section, the state's Title V agency, the Missouri Division of Maternal, Child and Family Health is responsible for chairing and staffing the Maternal and Child Health subgroup of the MC+ QA & I Advisory Group. The deputy director of the division of MCFH chairs the subgroup.

The Department of Health also distributes informational materials directly to the following groups, who in turn make them available to their students, patients and families. Those groups include Parents as Teachers, Head Start, schools (school nurses, family and consumer science teachers), community action agencies, health care providers in private practice and licensed child care centers.

A working partnership between the Division of Maternal, Child and Family Health (MCFH) and the Missouri March of Dimes to distribute materials about folic acid is also in place. In addition, MCFH is teaming up with Sudden Infant Death Resources, Inc., to disseminate print and electronic messages about placing babies on their backs to reduce the risk of SIDS (Back to Sleep campaign).

II. REQUIREMENTS FOR THE ANNUAL REPORT

This section describes Missouri's program activities in FFY 99, a complete record of expenditures of MCHBG funds, and the extent to which National and State objectives were met in the 1999 program year.

2.1 Annual Expenditures

Please refer to forms 3,4, and 5.

Form 3 reports an unobligated balance of $2,059,358 carried forward and spent in FFY99. Programs and activities that contributed to this under expenditure from the previous year included family planning, MCH contracts with local health agencies, and SHCN direct payments. In FFY99 major contributors to spending federal funds at lower than budgeted levels were again these same program areas, as well as home visiting programs. Federal family planning funds of slightly over $800,000 were not spent; contracts with local health agencies were under spent by $600,000; and CSHCN direct program payments were under spent by $560,000. Home visiting programs were slow in getting started and this resulted in an under expenditure of nearly $230,000 compared to the budgeted amount. Turnover in staff and a significant reorganization of the Division of Maternal, Child and Family Health contributed to under expenditures in the personal service budget. Various other programs and service areas contributed in lesser amounts to the under expenditure level in FFY 99.

State funds expended were $10,285,112 compared to a budgeted figure of $9,987,230. In addition, program income of $1,118,616 was earned and spent as a

result of agreements the DMCFH has with Medicaid. The income was realized as a result of programs and services provided for the Medicaid population through well child outreach; Healthy Children and Youth (the EPSDT program in Missouri); perinatal substance abuse services; Medicaid expansion for pregnant women and children; and the physical disabilities waiver of Medicaid.

Form 4, Budget Detail by Types of Individuals Served, shows a good correlation between budgeted and expended funds for the various MCH population groups except for "Infants >1Year Old" and "All Others." The former was underspent by $740,000 as both federal and state expenditures fell short of their budgeted amounts. "All Others" was under spent by approximately $850,000 primarily due to under expenditures in family planning.

Form 5, State Title V Program Budget and Expenditures by Types of Service, again shows a decline in the amount budgeted and spent for direct health care services. Even though federal family planning funds were underspent by $800,000, actual total expenditures would have nearly equaled the budgeted amount if all state family planning funds expended were reported. The state spent $5.2 million on family planning in FFY99 compared to a budgeted figure in the MCH Block Grant application of $3.8 million.

The trend in Missouri continues to be towards less emphasis on direct health care and more on the other three types of services. However, family planning services remain a priority of the Governor. Of the total expenditures in the partnership for direct health care services, family planning payments account for approximately 75%. This program will continue to keep the direct health care expenditure level high in order to meet the needs of women of childbearing age who do not receive Medicaid benefits, who do have insurance for this service, or who lack the financial resources to obtain this service.

Contracts with local health agencies to provide outreach and identification of children with special health needs and assisting families to obtain insurance coverage for this population met with an under expenditure of approximately $200,000. Program funds budgeted in the direct health care service area of SHCN were shifted to support infrastructure needs to include: continuing education for school nurses working with the special needs population; school evaluation for children with special needs; child care provider training in how to care for children with special needs; and assistance for

families of children with special needs in finding quality child care. State general revenue funds were used to provide direct care program payments.

Expenditures for enabling services were about 7% over the budgeted amount, but expenditures were over two and half times the expenditure level in 1998. Population based expenditures were almost $900,000 under the amount budgeted because of under expenditures of federal funds for home visiting and local health agency contracts as well as an under expenditure of state funds, largely concentrated in vaccines and outreach activities. Infrastructure building was nearly equal to the amount budgeted.

Missouri will continue to make adjustments to the changing needs and priorities of the state. The five year needs assessment will help provide guidance to decision makers as to where funds should be allocated to best meet the health care needs of its citizens. Fluctuations in budgeting and expenditures from year-to-year are expected as management surveys the changing health care scene, analyzes available data, and listens to the concerns of citizens, its constituents, and its partners across the state.

2.2 Annual Number of Individuals Served

Please see Forms 6,7,8 and 9

2.3 State Summary Profile

Please see Form 10

2.4 Progress on Annual Performance Measures

Please refer to Form 11

Through the use of Title V, State and other Federal resources, Missouri is able to report the following accomplishments. These accomplishments are described by each level of the pyramid – direct health care, enabling, population based, and infrastructure building services. Within each pyramid service level, descriptions are organized by required population groups: pregnant women, mothers and infants, children, and children with special health care needs.

2.4.A. Direct Health Care

1. Pregnant Women, Mothers and Infants

No material included

2. Children

No material included

3. Children with special health care needs

01: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

The State Disability Determination Unit (DDU) of the Social Security Administration (SSI) refers children under age 21 to Missouri's CSHCN program. Referrals are sent directly to BSHCN area offices from the DDU. The BSHCN provides an enrollment packet to each child referred and captures information from those returned in the Missouri Computer Assistance Resources for Enrichment Services (MOCARES) computer information system. The referrals of SSI beneficiaries less than 16 years old from the Disability Determination Office for FFY99 totaled 1642, however, of those, 485 (30%) responded to our correspondence and 284 (17%) met the financial and medical eligibility criteria to qualify for services provided through the BSHCN. Those referred that did not meet eligibility requirements are referred to the Department of Mental Health and Local Public Health Offices for services. A significant number did not respond to initial contact by the BSHCN. Assessment of this pattern is warranted over the next fiscal year to assure families have access to and are accessing services. However, beginning in February 2000, a direct contact is made on each SSI referral, with an eligible diagnosis, for those who did not responded to the initial correspondence. It appears that referrals are inconsistent statewide. Further clarification regarding differences in referral patterns from DDU across the state is needed. A collaborative effort is planned with DDU for identification and follow up of children with special health care needs to assure those that require services are receiving the services needed.

Sixteen percent (down from 18%) of the State SSI beneficiaries less than 16 years old received rehabilitative services from the CSHCN program in FFY99. Over 2450 SSI beneficiaries less than 16 years old received rehabilitative services from the CSHCN program in FFY99. SSI beneficiaries are accessing Medicaid managed care companies for comprehensive health services and SSI eligibility changes have reduced the number of children eligible to receive CSHCN services. A continued decrease in referrals and CSHCN enrollment is expected.

02: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to it clients.

The CSHCN program enrollment has decreased 20% during FFY99. This is a direct result of the SCHIP expansion in the state of Missouri and CSHCN program requirement of application into the Medicaid system prior to CSHCN eligibility determination. CSHCN continues to provide 8 of 9 units of specialty and subspecialty services for burns, cardiology, cleft lip/palate, myelomeningocele, genitourinary, neurology, neuro-surgery, orthopedics, and pediatric surgery. Services for arthritis, cerebral palsy, otolaryngology and physical medicine and rehabilitation are also provided. Units provided for these services included medical and surgical subspecialty services, therapy services (PT,OT, RT, ST), durable medical equipment and supplies, nutrition services and care coordination. Consideration may be given to the inclusion of home health services in the future because of previous and current trends of reduced number of hospitalizations and reduced length of stay for hospitalizations. Skilled interventions in the homes are necessary to manage post acute care.

The CSHCN program has begun laying the foundation for a statewide outreach campaign to raise awareness of the general public and health professions about the services offered. Feedback through parent interviews and health professionals reveal that the services offered by the CSHCN could have been utilized by participants sooner. In addition, families of participants emphasize that the program has provided gap filling services otherwise unmet. BSHCN local area offices are interfacing with local health departments to provide and obtain referrals. This effort will be continued in order to strengthen the local networks providing services to all children with special health care needs. Access to specialty inpatient services in the non-managed care rural areas has been identified as an issue for program participants during FY99.

Early intervention services are provided through IDEA First Steps Program administered by the BSHCN through the lead agency, the Department of Elementary and Secondary Education. The BSHCN serves 1025 children through part C of the IDEA First Steps program. Training for providers and service coordinators is promoting the “credentialing” process for assurance of services to this population with developmental disabilities. The CSHCN program provides early intervention for those that do not qualify for First Steps but meet eligibility criteria for the CSHCN program. These services would not otherwise be accessible or available to Missouri’s special

needs populations. BSHCN service coordination facilitates the allocation of resources for medical, habilitative, rehabilitative services, equipment and supporting technology. The BSHCN, through an interagency agreement with the Department of Social Services, provides administrative case management for children with special health care needs who participate in the Healthy Children and Youth program. The BSHCN works with the Bureau of Dental Health to provide and assure primary dental services for children with special health care needs.

In FFY99, Missouri began assignment of services for the adolescent with traumatic brain injury. Services for children under age 21, not otherwise covered through other systems of care, are now being supported through a pilot program within the Bureau of Special Health Care Needs. During this reporting period, BSHCN also expanded coverage for nutrition services to assure access to nutritional services for children with special health care needs. Planning with the Department of Social Services (Division of Medical Services) for further expansion of coverage for such services is underway.

2.4.B. Enabling Services

1. Pregnant Women, Mothers and Infants

Enabling Missouri's pregnant women, mothers and infants to access appropriate services was partially addressed during FY99 through the Department of Health's telephone information and referral service, TEL-LINK. During the FFY99 period, the number of calls received on this toll-free line totaled 9,924, an increase of 60 percent from the previous year (with 6,200 calls). This significant increase can be partially attributed to several new promotional activities that were developed, including six new television spots, three radio spots, "busboards," and MetroLink displays. In addition, three different newspaper/magazine ads were created and printed for several publications.

SP 01: Percent of women with inadequate prenatal care.

Inadequate prenatal care is defined as receiving fewer than five (5) prenatal visits for pregnancies of less than 37 weeks, fewer than eight visits for pregnancies of 37 weeks or longer. Prenatal care is considered inadequate if the first visit does not occur before the end of the fourth month of pregnancy. Based on the review of birth certificate data, the state rate for inadequate prenatal care was 11.0 percent for calendar year 1998, and 10.5 percent for calendar year 1999. However, there has been a steady

decline since 1980, when the rate was 18.2 percent. Projected percentages of inadequate prenatal care might be impacted by cultural norms among specific populations and shifts in the demographics of the population, access to services, and the number of births to non-documented aliens.

In FFY99, educational material was distributed to families and to professionals who have direct contact with families by the Well Child Outreach program. This material focused on the importance of preventive health care for pregnant women. Also, in collaboration with Medicaid, the DOH provided outreach services for the Healthy Children and Youth program, which included comprehensive exams for children and adolescents up to age 21. Women who were pregnant received prenatal care through the program.

SP O2: Percent of inadequate birth spacing.

The definition of inadequate birth spacing is a live birth occurring to a women who had a prior live birth within 18 months and the percent this number is of second and higher order births. In 1998, the rate was 10.5 percent, making a small increase in the calendar year 1999 period to 10.7 percent.

Prenatal Case Management and Family Planning programs implemented by the DOH require a determination of whether preconception counseling occurred for each client. The Department of Social Services, Division of Medical Services (Medicaid) funds preconception counseling as a part of its requirement for standard service provision. Appropriate birth spacing is a component of this education and counseling.

Through the Comprehensives Family Planning Program, in FFY99, any qualified Missouri resident who had reached reproductive maturity could receive family planning services. For FFY99, services included but were not limited to, medical history, physical assessment, assessment of STD risk, various screenings, lab work, and contraceptive methods and appropriate education.

Inadequate birth spacing was also addressed in FFY99 by the Families at Risk Home Visiting program, located at seven sites throughout Missouri. Based on the Missouri Community Based Home Visiting (MCBHV) model, these programs include visits by a Registered Nurse as well as a lay Family Support Worker over an extended period. One of the goals of this program was to decrease the number of recurrent pregnancies to women less than 18 months apart. Teaching family planning and client compliance with the chosen method was completed in the home setting.

Finally, the 112 Maternal and Child Health (MCH) services contractor's in FFY99 provided education on birth spacing, pregnancy testing, education and referral to family planning and other service providers to address inadequate birth spacing.

2. Children

During the FFY99 period, the Well Child Outreach program targeted families in its educational materials promoting the importance of comprehensive exams according to the AAP periodicity schedule, safety in the home, school, and vehicle, avoidance of secondhand smoke around children, normal child development to avoid child abuse due to inappropriate expectations, and positive fathering.

3. Children with special health care needs

03: The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."

Children with a special health care needs are considered to have a medical home in Missouri if there is documented evidence that regular visits are made to the same physician. This data is based on self reported information from enrolled participants/families as well as what is obtained through Department of Social Services (DOSS) provider billing system.

The Bureau of Family Health, through its seven home visiting program sites, addressed the issue of medical home as part of the regular curriculum. For FFY99 these sites reported that 98% of their participants, all at-risk families and therefore included children with special health care needs, had a medical home under the current definition. In addition, 112 local public health agencies (LPHA) in Missouri participating in the MCH services contract for FFY99, were required to identify and refer children with special health care needs to a medical home. Their efforts resulted in connecting 9,537 children with special health care needs in the state to a medical home.

Of clients served by the Bureau of Special Health Care Needs, 6118 clients or 61% which is up from 60% in FFY98, have a physician who is able to facilitate all aspects of pediatric care. This number is under reported because 15% of children served by BSHCN are over the age of 18 and Medicaid does not track children over the age of 18; 16% of children served by BSHCN have no insurance, public or private, and 48% have fee for service Medicaid which typically has fewer documented medical homes than MC+ managed care plans. The Missouri Health Strategic Architectures and

Information Cooperative (MOHSAIC) computer system is expected to be operational by November of 2000 and should capture more timely and valid CSHCN client data. The BSHCN's facilitators for HCY screening, focus on assisting families of children with special health care needs and any other children in the home, to obtain timely health screenings and immunizations. These facilitators inform the family of the screening/immunization need, identify providers, arrange transportation, and record their referrals into the MOCARES system.

The Missouri Partnership for Enhanced Delivery of Services, facilitated through the University of Missouri, Physical Medicine and Rehabilitation Department began enrollment for the project in November of 1999. The development of a coordinated system of care for children with special health care needs in Missouri includes local partnerships and collaboration among the University of Missouri-Columbia, University of Missouri – Kansas City, the Missouri Planning Council for Developmental Disabilities, District VI Community Access to Child Health (CATCH) and state agencies, including the Department of Health, Mental Health, Social Services, Elementary and Secondary Education, and Missouri's Interdepartmental Initiative for Children with Severe Needs.

2.4.C. Population-based Services

SP O4: Percent of citizens drinking fluoridated water.

The largest population-based services of the Bureau of Dental Health, deal with fluorides and water fluoridation and serves all three population groups. In FFY99, 75 percent or 3,250,000 persons on a community water supply had optimal fluoride available to them in that supply. (A portion of the Missouri population still has private wells.)

The Community Water Fluoridation Assistance Program provides equipment, training, technical assistance, and supplies for communities wishing to adjust the fluoride level of their water. As part of the water fluoridation program, information is provided to community leaders and the public to assist them in either beginning or maintaining their fluoridation systems. The bureau has an interagency agreement with the Department of Natural Resources (DNR) to provide the technical assistance on water fluoridation. The bureau, with advice from the state fluoridation engineer at DNR, purchases fluoridation equipment for new supplies and for those needing repairs or replacement of existing equipment.

1. Pregnant Women, Mothers and Infants

04: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).

The number of initial newborn screens completed by the State Public Health Laboratory was more than the number of recorded births for CY98 (+286 over 100 percent), and for CY99 (+3156 over 100 percent). These numbers are largely attributable to two factors: (1) babies born in neighboring states with the newborn screening done in Missouri; and (2) repeat newborn screens on infants who have had a name change that the State Public Health Laboratory were unable to match to the first screening thus counted again as an initial screening. Because of these factors, the number of infants screened is generally more than the actual number of births in Missouri.

05: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tentanus, Pertussis, Haemophilus Influenza, Hepatitis B.

The Healthy People 2000 Objectives include ensuring that 90 percent of children by age two complete the vaccine series recommended by the Advisory Committee on Immunization Practices. The immunization rates for 19-35 month old children increased from 78 percent in calendar year 1997 to 85.8 percent in calendar year 1998. These rates, obtained through the National Immunization Survey, were for the 4:3:1 series consisting of four or more doses of diphtheria and tetanus toxoids and pertussis vaccine/diphtheria and tetanus toxoids (DTP/DT), three or more doses of poliovirus vaccine, and one or more doses of measles-containing vaccine (MCV). The rate for the 4:3:1:3 series increased from 77 percent in calendar year 1997 to 84.5 percent in calendar year 1998. This series consists of four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of MCV, and three or more doses of Haemophilus influenzae type b vaccine (Hib).

In 1999, the immunization program began providing varicella vaccine to all children 1-18 years of age served by local public health agencies, hepatitis A vaccine to all Vaccines for Children (VFC)-eligible children 2-18 years of age, increased the number of VFC private provider clinics to 564, assessed the immunization rates of 40% of private VFC providers, and increased the number of active two-year-old children in the statewide registry to 51%.

The Families at Risk Home Visitation program provided education for enrolled parents on the necessity of immunizations and verified that the proper immunization schedule was followed for participating families. The seven program sites reported for FFY99 that 98 percent of their clients were up-to-date on immunizations.

09: Percentage of mothers who breastfeed their infants at hospital discharge.

In 1998, 60.3% of mothers breast fed their infants at the time of discharge in Missouri, as reported in the Ross Survey. This was a 2.2 percent increase in comparison to 1997 (58.1%) and 6.1 percent increase from 1996 (54.2%). During 1999, a survey of hospital nursery staff had indicated a need for basic training in breast-feeding initiation. Following that survey, two basic breastfeeding training sessions were conducted in the central and northwest parts of the state for health care providers. Other activities conducted during FFY99 were the development of two modules (Re-lactation and Breast Refusal) for the Breastfeeding Counseling Guide, distribution of breastfeeding information to physicians, and the drafting of Missouri's Five Year Breastfeeding Plan. The Statewide Breastfeeding Task Force was instrumental in developing the plan. In addition, legislation was passed allowing women to breastfeed in public and private areas. The legislation also required obstetrical health care providers to promote breastfeeding and to distribute breastfeeding information to pregnant women.

In FFY99, women in the Infant Mortality Reduction Program received group and individual education regarding breastfeeding. Breast pumps were distributed to mothers as needed, and the Bootheel Healthy Start program provided additional funds for the purchase of breast pumps.

10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.

The Bureau of Disabilities Prevention and Injury Control continued to contract with Southwest Missouri State University during FFY99 to conduct a pilot project for newborn hearing screening. The university collected data from six pilot hospitals which operated a universal newborn screening program. The university also provided resources and consultation to hospitals interested in developing similar programs. In FFY99, 4.5% of newborns in Missouri had their hearing screened. This was an increase from 1.2% in FFY98. The data obtained through the pilot program was helpful for

passage of 1999 legislation which mandates all hospitals to screen the hearing of newborn children.

SP 05: Percent of women who have reported smoking during pregnancy.

Birth certificate data indicated that 19.0 percent of Missouri women smoked during their pregnancy in 1998 as compared with 18.3 percent in 1999. Prevalence studies for the use of tobacco, alcohol and other drugs during pregnancy were conducted in 1993 and in 1997. Prevalence for perinatal smoking in the 1993 study was approximately 22 percent and 21 percent for 1997. The most prevalent substance used during pregnancy in 1993 and 1997 was tobacco, with an estimated prevalence of more than one-in-five for both periods. The prevalence for the under 20 age group as measured by urine specimens increased from 17.1 in 1993 to 23.2 for 1997, with a less dramatic increase noted for women ages 20-24 (25.2 to 27.1).

There are many factors that may influence the data or changes in the smoking prevalence rate, for example (1) birth certificate data is gathered from client reporting which basically reflects last trimester usage; and (2) incidence of smoking behavior is increasing among adolescents. Additionally, tobacco company marketing has targeted adolescents. Federal and state legislation concerning tobacco use, cost and availability could affect projected percentages, as well as the impact of public and professional education on the risks of tobacco usage during pregnancy. Other factors that might affect the incidence of smoking include the cost, availability and effectiveness of smoking cessation programs and counseling.

The Bureau of Family Health's Perinatal Substance Abuse Program, in collaboration with other agencies, offered training and education to health professionals to assess and implement perinatal smoking cessation programs in clinics and health practices throughout the state. In FFY99, the Perinatal Substance Abuse Program conducted smoking cessation education, supported education provided by other sites such as WIC, facilitated the purchase and use of culturally competent, updated literature available to providers from the Department of Health and submitted a request for a Robert Wood Johnson Foundation grant on smoking cessation during and after pregnancy. Finally in FFY99, the Well Child Outreach program provided education to families and to professionals who have direct contact with families about the importance of avoiding tobacco while pregnant and protecting infants and children from exposure to second hand smoke.

2. Children

In FFY99, the Missouri Department of Health provided funding to 127 contractors throughout the state for school-age children's health services, serving approximately 219,000 children. The overall goal was to enhance the health status of children through increasing access to primary and preventive health care by providing population-based services through schools. For this FFY99 period, 42.4% of the children received a comprehensive health exam in the last two years; 38.2% of the children had a routine dental visit in the previous 12 months.

Also during this period, the number of public schools with routine access to registered nurses increased from 80% to 86%. The number of public schools involved in contracts increased to 242, and the number of private or parochial schools receiving services increased to 95. The programs deliver basic school health services such as identification of children with special health care needs, development of health plans to address those needs, safe administration of medication, appropriate care of illness and injury and routine screening programs. The enhanced level of service provides more comprehensive programs to address physical and mental health services through the use of social workers and mental health professionals.

06: The birth rate (per 1000) for teenagers aged 15 through 17 years.

The rate of births to adolescents, 15-17 years old, continues to decline. In FY98, the rate was 31.0 per 1000 and in FY99, the rate dropped to 29.1 per 1000. Pregnancies declined proportionately from 40.1 per 1,000 in FY98 to 36.7 per 1,000 in FFY99.

Using available federal monies, Missouri is actively seeking contractors for abstinence-only education. In FY99, Missouri funded 15 contractors and reached 11,911 adolescents 10-18 years of age through curriculum-based programs. These contractors presented programs in schools and community settings. Many of the contractors approached the problem of sexual activity in the context of character education and personal responsibility. The use of peer educators continued to be a strategy used by a number of contractors. A large number of adolescents were exposed to the abstinence message through one-time presentations such as rallies and assemblies. All of the programs incorporated parent education to assist parents in communicating with their adolescents around sexuality. Approximately $770,000 was allocated for FFY99, targeting primarily 10-14 year olds.

The evaluation of county-based adolescent pregnancy prevention programs was completed September 30, 1998. The Bureau of Family Health contracted with the Center on Adolescent Sexuality, Pregnancy and Parenting (CASPP) at the University of Missouri Outreach and Extension. The evaluation report detailed: (a) methods used by counties that successfully implemented postponing sexual involvement programs; (b) common barriers to implementing programs; (c) practices that helped counties overcome barriers to implementation; and (d) perceived benefits of the programs. A decision was made to offer continued funding to those contractors that appeared to be most successful. Over 3,386 adolescents in Missouri participated in county based pregnancy prevention programs in FFY99.

In 1999, the Bureau of Family Health convened an adolescent and school health advisory task force. The purpose of the task force is to advise and make recommendations to the department regarding adolescent and school health issues and initiatives. The task force recommended that the department use funding available for adolescent health to provide education for parents of adolescents with the aim of reducing adolescent risk behaviors (including early sexual activity leading to pregnancy and STD's).

07: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

The dental sealant initiative in Missouri has both treatment and educational activities. The sealant program operates in both inner-city St. Louis schools and in private dental practice-based initiatives in 84 Missouri counties. Sealants are applied by dentists in school settings, in private dental offices and in public clinics. Providers are paid on a fee-for service basis. Sealants are provided for non-Medicaid children below 185 percent of the federal poverty level. Children who are eligible for the sealant program are those whose family incomes qualifies them for the federal school lunch program. In addition, the sealant program provides information to practicing dentists and local health agencies across the state to help increase the availability of sealants for all children.

The approximate number of children with sealants in Missouri was 16,010, or 11.75 percent of the total number enrolled in the second and seventh grades (136,254) in FFY97. This information is based on a statistically representative sample from the 1994-1995 academic year of 48 second and seventh grade children. Estimates for

FFY99 remain the same as for FFY97, since the most recent statewide survey has been occurring during the 1999-2000 school year.

The Bureau of Dental Health also administers a statewide fluoride mouth rinse program within selected schools to over 110,0000 participants. Fluoride mouth rinse and accompanying materials are provided, and children receive a weekly fluoride mouth rinse under adult supervision.

08: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Missouri's death rate for children 1-14 from motor vehicle crashes was 6.4 per 100,000 in 1998 and 4.6 per 100,000 in FY99. The SAFE KIDS Coalition was established in Missouri in 1991 to begin addressing deaths among children (1-14) that can be attributed to motor vehicle crashes. The SAFE KIDS Coalition is staffed and coordinated by the Bureau of Disabilities Prevention and Injury Control. The Coalition's mission is the prevention of unintentional injuries in children ages 14 and under, and is primarily focused on the following major injury risk areas: traffic injuries, fires and burns, falls, drowning, poisoning and choking. This coalition provides technical and program assistance, training, consultation and funding to local coalitions in seven Missouri communities to carry out community-based injury prevention activities. Preventive activities included safety seat checkpoints and training of parents and caregivers in child passenger seat installation and use. Local coalitions replace defective or recalled seats, provide safety seats for needy families, distribute safety literature; and work with the media to broadcast safety messages. The BDPIC through the Injury Control Advisory Committee, collaborates with other agencies and private entities to facilitate community injury control initiatives.

Through the MCH Services contracts with local public health agencies, local communities addressed this measure by conducting safety seat educational programs and giving seats to families who could not otherwise obtain a safety seat for their young child. Local public health agencies also conducted safety belt and bike helmet education in school settings. Public service announcements on the radio, television, and newspapers were also initiated.

SP 03: Percent of low income children ages 1-11 who consume nutritionally adequate diets.

In FFY99, the Bureau of Nutrition Services and WIC (NSWIC) began to expand the use of the food frequency questionnaire (FFQ) across the state at all WIC agencies. The expansion is ongoing. A FFQ Task Force has been convened to provide recommendations on some logistical issues related to the tool. Based upon federal recommendations, NSWIC in collaboration with the Harvard School of Public Health is in the process of determining the criteria for an adequate nutritional diet that would be utilized by all states using the computerized FFQ developed by that university. Due to the logistical issues, no data is currently available for FFY99. Harvard University has also been contracted to modify its FFQ to obtain information from the 10-18 year old school population.

In FFY99, NSWIC coordinated with the Bureau of Nutrition and Child Care Programs (NCCP) to introduce the FFQ tool for use in schools. NSWIC developed and provided training to school nurses receiving school health grants on obtaining accurate height and weight data and food frequency information. NCCP received funding from USDA's Team Nutrition Grant to validate this Youth FFQ for 10-18 year olds. Data collection for this validation began in September 1999 at the Hickman Mills School District in Kansas City. The Youth FFQ is also being utilized through the Missouri School-Age Health Services Program (MSCHS), which funds public schools and local public health departments to provide health services to school children. MSCHS is administered through the Bureau of Family Health.

For the 1999/2000 school year, MSCHS grantees were required to meet a mandatory nutrition measure. This grant specified that the nutrition measure requirement should be met by the administration of the Youth FFQ to children who are nutritionally at risk as determined by the body mass index. Data collected through the MSCHS will be added to the expanded Pediatric Nutrition (PedNSS) in FFY 2000.

3. Children with special health care needs

In FFY99, funding was allocated to the Missouri School Aged Children's Health Services (MSCHS) program for activities to enhance the ability of schools and local health departments to serve children with special health care needs. Funding was used to purchase materials and audio-visuals for training school staff to care for students with special health care needs. The availability of these materials was highlighted in

newsletters to school nurses. Approximately 13.4% of children served through the MSCHS contract in FY99 were identified as having a special health care need. In FY99, eighty-nine (89) contractors received approximately $193,175. The contracts provided the following:

- 51 contractors purchased materials that benefited the entire school population at 51 schools, e.g. equipment for better identification of special health care needs;
- training for 925 teachers related to caring for children with special health care needs;
- additional equipment for 269 children with asthma to use at school;
- additional equipment for 13 children with diabetes to use at school;
- equipment for 8 children with speech and language disorders; and
- mental health services for 40 children

The DOH contracted for a media campaign to increase awareness of parenting assistance available to parents of children with special health care needs. The print media carried the message "your questions are as unique as your children." The packet of information advertised the availability of a "warm line" for parents and professionals. Fourteen percent of calls to the "warm line" related to special health care need topics.

The CDC Birth Defects Grant awarded to the Missouri Department of Health, will impact children with Special Health Care Needs by: (1) improving the state-based birth defect surveillance system through more timely and accurate detection of birth defects; (2) linking state-sponsored genetic database with the Birth Defects Registry; (3) implementing strategies to use Birth Defects Registry data to improve service delivery for children diagnosed with Spina Bifida; and (4) conducting surveillance of interventions to prevent neural tube defects. Within the Bureau of Special Health Care Needs, this grant has assisted the facilitation of genetic counseling and statewide service coordinator training.

2.4.D. Infrastructure-Building Services

SP 06: Percent of MC+Managed Care Organizations (MCOs) utilizing MCH data.

In FFY99 there were nine MC+ Medicaid managed care plans operating in three Missouri regions that included the Kansas City, St. Louis, and the central Missouri markets. All of the MCOs participate in the MC+ QA & I Sub-Group staffed by the Division of Maternal, Child and Family Health and use MCH data. The Sub-Group has now received training on how to access MCH statistical profiles on the *Missouri Information for Community Assessment (MICA) system.* The MCH Profiles are computerized resource pages that provide information to MCOs and other users on a

specific MCH indicator, including a definition of the indicator, risk factors, description of the condition, intervention strategies, state related programs, community programs and resources, contracts and grants educational material, and other web sites pertaining to the MCH indicator.

Through MICA and other sources, MC+ managed care plans have been provided with MCH health status indicator rates for Missouri. Working with these managed care organizations, MCH data has been used in the development of best practices to reduce smoking in pregnancy, to reduce the percent of inadequate prenatal care and to increase the percent of children that have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B by their second birthday.

1. Pregnant Women, Mothers and Infants

15: Percent of very low birth weight live births

Very low birth weight is defined as less than 1500 grams. For 1998, the rate for very low birth weight for all races was 1.4 percent (1.1 percent for Caucasians and 3.2 percent for African-Americans). In calendar year 1999, the very low birth weight for all races was 1.5 percent.

The Bureau of Family Health implemented pilot Infant Mortality Reduction Projects in 1996 to establish community-based initiatives to address infant mortality in areas with high rates and reduce the racial disparity between the African-American and Caucasian infant mortality rate. Three areas in Missouri were targeted for pilot projects: Kansas City, St. Louis, and the Bootheel. Projects in each of the three locations include some of the following: developing peer leaders within the African American churches, block parties in the Housing Authority, baby showers, youth rallies, church workshops, health fairs, education of pregnant teens regarding the importance of prenatal and postnatal care, teaching abstinence, self esteem and parenting classes, promotion of breast feeding and WIC, issuing Temp Medicaid cards to pregnant women so they may begin prenatal care, providing education for men and fathers, bereavement training, working with local media to publicize community activities targeted at reducing infant mortality, and development of community collaborations. Finally, some of the projects are participating in the “This Side Up” campaign to promote placing infants on their backs to sleep. In addition to the activities outlined above, the following BFH programs impact the reduction of very low birth weight, primarily by improving access to care and

by helping to ensure earlier prenatal care: (1) Abstinence Education, designed to prevent unintended pregnancies in adolescents, who are at higher risk of having low birth weight infants; (2) training for health professionals on ways to reduce infant mortality, through a contract with SIDS Resource; (3) Temporary Medicaid for Pregnant Women Program (TEMP); (4) Prenatal Case Management provides case management services for Medicaid-eligible pregnant women; (5) the Perinatal Substance Abuse Program, which provides a range of services including care coordination aimed at reducing the use of tobacco, alcohol and other drugs during pregnancy; and (6) the MCFH toll-free information and referral line, 1-800-TEL-LINK, which assists families in obtaining referrals related to a wide range of health services which may increase the number of healthy birth weight babies.

17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

During calendar year 1998, data collected from hospital records indicated that 81.6 percent of very low birth weight infants were delivered at facilities for high risk deliveries and neonates. This dropped to 78.4 percent for calendar year 1999.

This data has not been specifically collected in the past, and there are no specific programs aimed at increasing the rates. Data might be used in determining factors that affect these rates and to aid in determining service needs. Factors that might affect rates include unexpected obstetrical emergencies, geographic location of pregnant clientele and facilities, service plans' rules and regulations, effective client education concerning the signs and symptoms of early labor and/or high risk pregnancies, and access to emergency transport.

18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester:

Prenatal care began during the first trimester for 84.9 percent of pregnant Missouri women during calendar year 1998, and 85.6 percent in calendar year 1999. Several programs and initiatives in FFY99 addressed the issue of prenatal care in the first trimester. The Infant Mortality Reduction Program emphasized early prenatal care through individual counseling, home visits, and community education. Preconception care was provided through an extensive Family Planning Program affecting the frequency of pregnancy, birth spacing, and referral for prenatal services. Educational

components included culturally-sensitive education about the importance of early prenatal care. Through the Alternatives to Abortion Program, during the FFY99 period, prenatal care was included as a reimbursable service. When prenatal care was identified as an unmet need by case managers, women at risk of having an abortion were provided the appropriate prenatal care, which could begin at any point during the at-risk pregnancy. In addition, the MCFH division operated TEL-LINK, a telephone information and referral service, for prenatal care providers and supportive maternal, child and family health services. The Department of Health continues to collaborate with the Department of Social Services on Temporary Medicaid during Pregnancy (TEMP), which offers immediate eligibility for ambulatory prenatal care services to obstetrical care, including laboratory tests and prescriptions related to the pregnancy. Also in FFY99, local public health agencies (LPHA) participating in the MCH services contract, conducted outreach and case management activities to encourage early entry into prenatal care. LPHAs also provide client and community education, referral for prenatal collaboration with school nurses, prenatal, and childbirth preparation classes, and follow-up on missed prenatal care visits.

2. Children

12: Percent of children without health insurance

In FFY99, the 112 MCH contractors identified 23,835 children throughout Missouri without health insurance, and referred 22,826 children to Medicaid/SCHIP. Also, 277 of those children identified received other insurance coverage. Additionally, the Well Child Outreach program provided outreach services to inform families about the availability of MC+ for Kids. Print materials were distributed at public events and professional conferences.

Families of children with special health care needs are disproportionately low income and therefore are at a higher rate for being uninsured. The Medicaid expansion program (SCHIP) has facilitated coverage for more children in Missouri and for primary care services, previously not available to children with special health care needs. In FFY99, 52% (up from 46%) of CSHCN participants had Medicaid (as a result of SCHIP implementation), 20% percent had private insurance; and 12% (up from 10 percent) had both Medicaid and private insurance. The service coordination process helps to assure that all clients utilize the resources for which they are eligible from private or other public systems, thereby utilizing Title V funds as payer of last resort to fill in service gaps.

SCHIP (Title XXI) implementation has assisted in enrollment of children with special health care needs children into Title XIX (Medicaid) as well as Title XXI in Missouri. These efforts to enroll children with special health care needs in mainstream health plans, have been the primary factor in a 20% decrease in enrollment of clients in the CSHCN program managed by the MCFH division. As of February 2000, 56,673 children have been enrolled in the State Children's Health Insurance Program for Missouri.

13: Percent of potentially Medicaid elilgible children who have received a service paid by the Medicaid Program.

In 1998, an estimated 431,832 children (92.4 percent) in Missouri received a service paid by the Medicaid program and in 1999, an estimated 403,946 children (78.7%) received some type of service paid by Medicaid. This appears to represent a significant increase over the number of children receiving Medicaid services from FFY97 (261,504 or 56.1 percent). However, for FFY 1996 and 1997, the HCFA 2082 Annual Report did not include MC+ (Medicaid managed care) recipients. Beginning in FFY 1998, the 2082 report included both fee-for-service and managed care recipients, resulting in the significant increase shown in the number of children receiving services paid by Medicaid. The number of children in Missouri receiving a service paid by the Medicaid program has increased largely because of the SCHIP and Medicaid enrollment initiatives referenced in the above discussion of the percent of children without health insurance.

16: The rate (per 100,000) of suicide deaths among youths 15-19.

The rate of suicide among Missouri's 15-19 year olds per 100,000 for calendar year 1999 was 12.6 or a 9.6 percent increase over the 1998 rate of 11.5. The continued trend of using firearms to commit suicide is a major factor in sustaining the trend of suicides among this age group.

The Department is now focusing on suicide as a major threat to public health. In August 1999, the BDPIC held a regional conference on suicide prevention in Kansas City, MO. The bordering states of Nebraska, Kansas and Iowa also participated. The conference brought in professionals and advocacy groups from all over the country. Each of the states met separately to determine the next step in their prevention effort. As a follow-up to the Kansas City conference, Missouri held a suicide symposium in October 1999. Approximately forty participants attended the symposium.

The Bureau of Disabilities Prevention and Injury Control continues the process started in 1999 of awarding mini-grants to six targeted Missouri communities. The counties are being asked to assess their community resources and needs, and develop suicide survivor support groups. These communities will also send members to the Department of Health's gatekeeper training. The BDPIC is actively working to ensure that gatekeeper training is provided to agency personnel and 100 community representatives.

Many Missouri school districts now address the suicide issue through implementation of student assistance programs, which are multi-disciplinary teams who receive referrals from all school staff, students and parents. A team member follows up with the student to determine a need for referral services. The Missouri School-Age Children's Health Services (MCHS) Program is actively involved in suicide prevention. Through this program, school nurses, school social workers and other mental health professionals identify students in need of services and work to assist the student to access appropriate care. Forty-one (41) social workers received full or partial salaries through the MSCHS program. This program provides referrals and funding for mental health services. The DOH, Division of Maternal, Child and Family Health, Bureau of Family Health has a TEL-LINK line to refer individuals to areas of assistance, including those at risk of attempting suicide.

In FFY99, the department also participated in the field testing of a mental health curriculum for school nurses that was designed to enhance their skills in identification of mental health concerns, including depression and suicidal ideation (April and June, 1999). Thirty-two school nurses took part in the program. In addition, representatives from DOH, Division of Maternal, Child and Family Health participated on all interagency teams related to child and adolescent health issues.

SP 07: Percent of children under age 2 with a reported subdural hemotoma.

This item is likely to remain inactive for an indefinite period due to a lack of data reporting and collection systems required to track this measure.

SP 08: Percent of child care facilities receiving health consultation.

The Child Care Health Consultation Program is a statewide collaboration between the DOH and over 100 local public health agencies (LPHAs) in Missouri. LPHA trained health consultants provide health consultation and training for child care

providers in their respective communities. During FFY99, 1,743 child care facilities received 887 hours of on-site health consultation and 2462 hours of training on health topics. The LPHAs also conducted 770 health promotion activities, teaching the children of child care facilities basic health and safety practices. The child care facilities impacted by health consultation increased 58% between FFY98 and FFY99. The continued increase in the number of child care providers receiving health consultation can be attributed to: increased awareness of the program; targeted training for health consultants to improve the quality of consultation services provided; and increased public demand for healthy and safe child care.

3. Children with special health care needs

11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

Many children with special health care needs come from families with disproportionately low income and therefore are at a higher risk for being uninsured. The Medicaid expansion program (SCHIP) has facilitated coverage for more children in Missouri and for primary care services, previously not available to children with special health care needs. In FY99, 52% (up from 46%) of CSHCN participants had Medicaid (as a result of SCHIP implementation), 20 percent had private insurance; and 12% (up from 10 percent) had both Medicaid and private insurance. The service coordination process helps to assure that all clients utilize the resources for which they are eligible from private or other public systems, thereby utilizing Title V funds as a last resort. SCHIP (Title XXI) implementation has assisted in enrollment of special health care needs children into Title XIX as well as XXI. In FFY, these efforts have resulted in a 20% decrease in enrollment in the CSHCN program managed by the Division of Maternal, Child an Family Health.

14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

The BSHCN currently encourages family participation in workshops, conferences and specialty functions. The Genetics Disease Advisory Committee, the Head Injury Advisory Council, First Steps, State and Local Interagency Coordinating Councils, and other small groups comprised of state agencies, local agencies, parents and other stakeholders are all involved with various special health care needs issues.

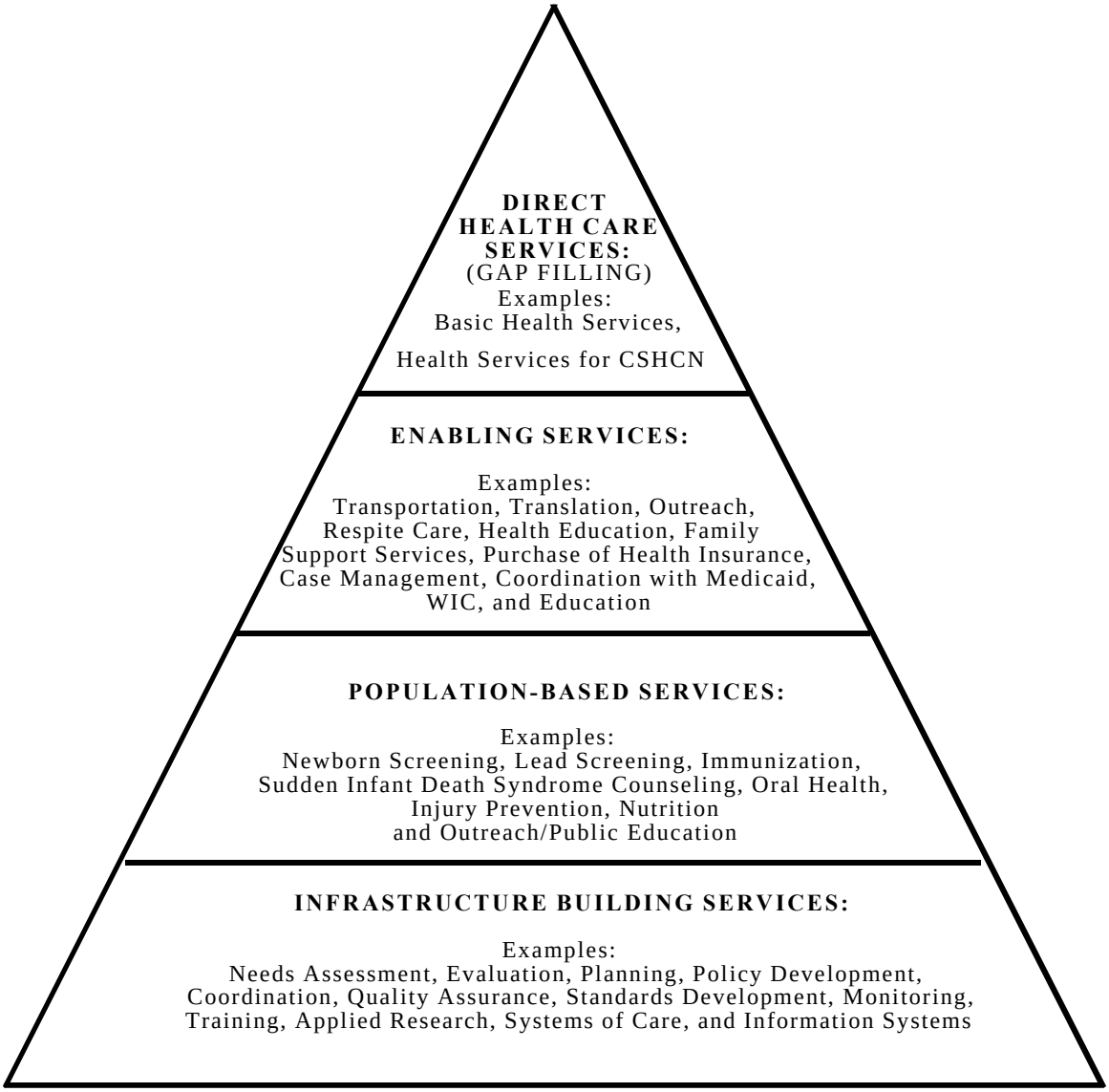
In FFY99, the BSHCN provided opportunities for several families who have children with special health needs children to attend training and education conferences, along with BSHCN staff. These conferences, focusing on children with special needs and supportive technology, provided a focal point for families to communicate and share their experiences. Some of these families participated in coalitions and partnerships with the BSHCN. Families were given the opportunity to assist BSHCN in determining priorities and strategies to ensure that children with special health care needs receive quality care, particularly as they transition and enroll in the Title XXI initiative. These and other opportunities for family collaboration are continuing in FFY2000.

2.5 Progress on Outcome Measures

Please refer to form 12, Tracking Health Outcome Measures. Outcome measures are the "ultimate focus and desired result of any set of public health program activities and interventions," and are usually collected over a long period of time. A performance measure describes a specific MCH need, or requirement, that when successfully met, will lead to an improved heath outcome. Interventions and activities relating to each specific performance measure have been discussed throughout Section II above, and will ultimately impact health outcomes. The specific outcome measures prescribed by HRSA/Maternal and Child Health Bureau are related to tracking the frequency and progress in reducing infant mortality (neonatal mortality, postneonatal mortality, perinatal mortality) and the death rate among children aged 1-14.

Figure 3

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



III. REQUIREMENTS FOR APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

The Title V agency for Missouri (Division of Maternal, Child and Family Health) has recently drafted an MCH need assessment for this 5 year cycle identifying the need(s) for:

- preventive and primary care services for pregnant women, mothers and infants;
- preventive and primary care services for children; and,
- services for CSHCN. [Section 505 (a)(1)]

The methodology followed, was consistent with health status goals and national health objectives for the above MCH population groups.

3.1.1 Needs Assessment Process

Multiple methods were applied by this agency to support its Title V need/capacity assessment. While any one method represents a unique but imperfect perspective, the use of multiple methods has the advantage of identifying need and capacity more fully. This assessment included but was not limited to the following methods:

- Review and analysis of previously conducted local assessments for over 100 counties in Missouri. The profiles for each of the counties analyzed included assessment/health problem issues. Many of those problem issues translated into specific MCH needs. (http://www.health.state.mo.us/profiles/County)
- Inventory and collection of secondary data and statistics for MCH population groups routinely collected by CHIME. (http://www.health.state.mo.us/MICA/nojava.html)
- Qualitative primary data generated through 12-15 focus groups conducted throughout Missouri broken down into two cohorts
  - Client (user) group cohort
  - Provider or agency group cohort
- A composite analysis of six MCH indicators related to unintended pregnancies, mothers who smoked during pregnancy, infant mortality, adequate prenatal care, teenage pregnancies and low birth weight babies to better focus geographic, ethnic and income disparities among MCH population groups.
- The application of specific formulas and formats recommended in HRSA/MCHB guides such as *Focus on Children: Community Planning Manual*

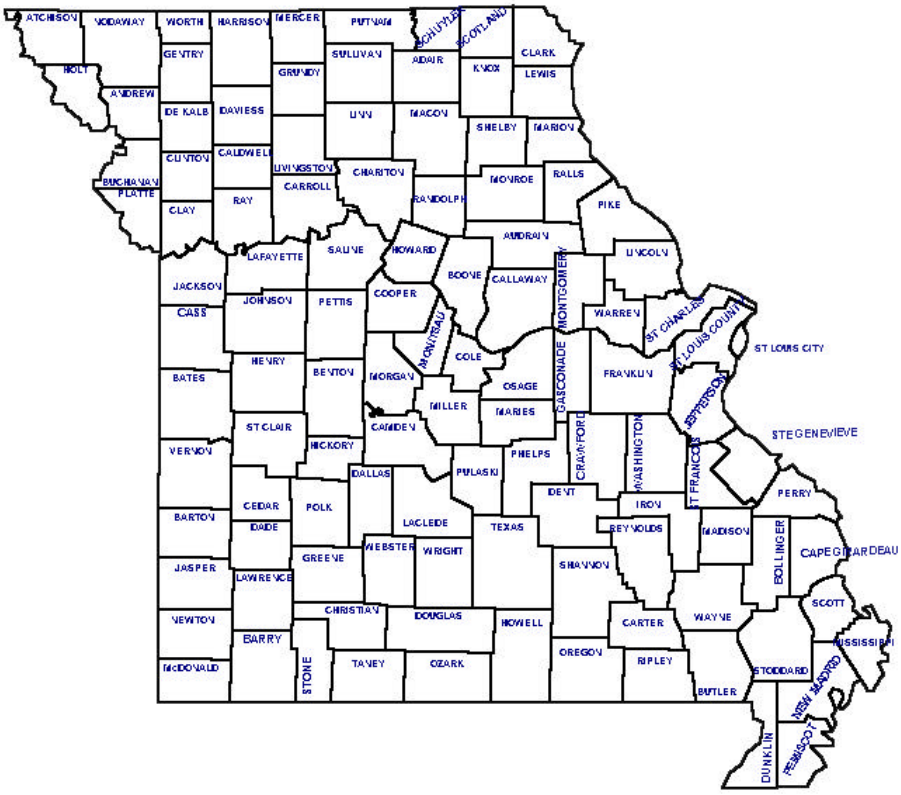
- The application of specific formulas and formats recommended in the *MCHB Guidance and Forms for the Title V Application/Annual Report*
  - Direct Health Care Services
  - Enabling Services
  - Population-Based Services
  - Infrastructure Building Services
- Review of current MCH research and taskforce/commission reports. (bibliography included with *Glossary*)

Examples of collaboration included the above mentioned focus groups, the Healthy Missourians Show Me Results Sub-Cabinet, The "Governor's Conference on Health: Children, Missouri's Most Valuable Resource" and a MCFH meeting with MCH stakeholders to review the assessment presented in this section and help determine MCH priority need areas for Missouri which are also included in this section.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

As of July 1998, there were an estimated 5,438,559 persons living in Missouri.



See the Population EstimatesTable included in the Other Supporting Documents Section 5.3, Table 3. Of the total population, 2,633,300 or 48 percent were males and 2,805,259 or 52 percent were females. Of the total Missouri population 86 percent of persons living in Missouri were white; 11percent were African American; 2 percent were of Hispanic origins; and 1 percent were of other ethnic origins. Since 1990, Hispanics have been the fastest growing racial ethnic group in Missouri. It is now estimated that there are 86,893 Hispanics living in Missouri, this is a 48 percent increase over 1990 census estimates. The total percentage of whites living in Missouri has declined slightly by 1.1 percent and the percentage of blacks within the total population has increased by .6 percent from 1990 census estimates.

The population of women of childbearing age is increasing. In 1998, there were 1,198,407 females between ages of 15 and 44 in Missouri. A total of 200,879 (16.8%) were women from the ages of 15 to 19. Between 1992 and 1997, the number of women of child bearing age increased by 23,300 or 13 percent. In 1998, there were 75,242 live births in the state of Missouri, which represented a fertility rate of 62.8 per 1000 women. Between 1990, and 1998, the number of live births among whites declined by 3.5 percent and the number of births among blacks for the same period declined by 16.0 percent. Between 1990 and 1995, the total number of births in Missouri decreased from 79,135 to 72,804. However, during this same period of time, the number of births among mothers eligible for Medicaid increased from 22,906 (28.9 percent of total births) to 29,318 (40.2 percent of total births).

The size of the under age five group shrank from 11 percent of the state's total population in 1960 to 7 percent in 1990. It will shrink to just over 6 percent in 2020, to 359,000 children, fully 100,000 less than in 1960. The 5-13 age group also declined dramatically between 1960 and 1990, falling from 17 to 13 percent of the total population. By 2020, this age group will number about 650,000, or 90,000 less than in 1960.

The 14-17 age group is somewhat larger than it was in 1960, numbering 275,000 persons today. It is projected to increase to 312,000 before falling to 294,000 persons in 2020. The 18-24 age group now numbers around 520,000 or 10 percent of Missouri's total population.

Missourians are continuing to migrate to "open-country" settings (those that live outside of incorporated municipalities). The open-country population increased in all but

12 of Missouri's 115 counties from 1990-1996 with the town population showing a decline in 88 of the 115 counties.

Selected demographic information from 1998 comparing Missouri with the United States and compiled by the Center for Disease Control, can be summarized as follows:

	Missouri	United States
Population	5,438,559	270,298,524
Population Density (persons/square mile)	78.9	76.4
Median Age	35.8	35.2
Percentage of Population		
Age > 65 Years	13.7	12.7
Age> 85 Years	1.8	1.5
Percentage of Population Male/Female	48.4/51.6	48.9/51.1
Percentage of Population Below Poverty Level	9.8	12.7
Percentage of School-Aged Children Below Poverty Level	14.4	17.8
Percentage of Live Births to Females Aged 10-17 Years	5.0	4.9

	Missouri	United States
Race/Ethnic Distribution of Population		
Percentage White	87.2	82.5
Percentage Black	11.1	12.7
Percentage Asian/Pacific Islander	1.1	13.9
Percentage American Indian/Alaskan Native	0.4	0.9
Percentage Hispanic	1.6	11.2
Educational Attainment > 25 Years		
High school graduate or more	82.9	82.8
Completed bachelor's degree or more	22.4	24.4
Number of Counties	115	3,136
Number of Local Public Health Agencies	125	2,918

Positive Trends

Missouri continues to make significant progress in increasing the rate of women seeking first trimester prenatal care and reducing the rate of pregnancies among

teenagers under age 18. In 1990, 77.6 percent of pregnant women began prenatal care in the first trimester; in 1998, the rate increased to 84.9 percent of pregnant women seeking prenatal care in the first trimester. The number of pregnancies among teenagers under age 18 decreased from 15,818 in 1990 to 4,619 in 1998. The teenage pregnancy rate has steadily declined from 58 per 1000 in 1990 to 38 per 1000 in 1998. Missouri has also achieved significant reductions in the percent of pregnancies resulting in induced abortions. In 1988, 18,379 pregnancies ended in induced abortions, this was reduced to 12,751 abortions in 1998. The rate declined from 19.3 percent in 1988 to 14.4 percent in 1998. Since the inception of the State Children's Health Insurance Program (SCHIP) in 1997, over 55,000 children have been enrolled in Missouri's SCHIP initiative. This represents over 60 percent of the estimated number of children (91,305) in Missouri that would qualify for enrollment and who would have no alternative health insurance coverage.

The rate of births occurring less than 18 months since previous births reached a peak in 1991 at 14.3 percent then declined to 10.5 percent in 1995 and has remained flat since 1995: 10.7 percent in 1996, 10.8 percent in 1997, and 10.5 percent in 1998. Smoking during pregnancy decreased from 26.1 percent in 1988 to 19 percent in 1998. The percentage of births to mothers enrolled in WIC has decreased since 1996 and the percentage of births to mothers enrolled in Food Stamps has decreased from 24.4 percent to 16.5 percent in 1998.

The immunization rates for 19-35 month old children in Missouri increased from 78 percent in calendar year 1997 to 85.8 percent in calendar year 1998. These rates, obtained through the National Immunization Survey, were for the 4:3:1 series consisting of four doses of (DTP/DT), three or more doses of poliovirus vaccine, and one or more doses of measles-containing vaccine (MCV). The rate for the 4:3:1:3 series increased from 77 percent in calendar year 1997 to 84.5 percent in calendar year 1998. This series includes (Hib) vaccine.

As in other parts of the nation, employment rates are the highest and unemployment rates the lowest for adolescents and women of childbearing age than at any time in the last thirty years.

Continuing Concerns

While the rate of pregnancies resulting in healthy birth-weight babies has improved, the percent of live births resulting in healthy birth-weight babies has remained

relatively flat since 1995. The same holds true for infant mortality. After achieving decreases in the rate for several years there has been no significant change since 1995.

A significant disparity exists between white infant mortality and black infant mortality in Missouri. In 1998, the infant death rate for white infants was 6.1 per 1000 live births whereas the rate for black infants was 16.7 per 1000 live births. There are readily apparent disparities between African-Americans and all other race/ethnic groups for virtually every outcome indicator. Preterm birth is most prevalent among African-Americans, while the African-American LBW rate is about double the rate for most other groups. The overall infant death rate is about double the rate for most other groups. Pregnancies among African-American women were more than twice as likely to end in fetal death than those in other groups.

An increase in women who are 20% or more overweight is occurring, especially among black and Hispanic women. This trend is related to labor and delivery complications and large sized babies.

Births to Women who are 20% or more overweight for height	1990	1998
White	21.0%	31.5%
Black	27.9%	42.2%
Total	22.0%	32.8%

According to the Youth Risk Behavior Survey, Missouri had the 2nd highest teen smoking rate in the nation in 1995 and 5th highest in 1997 although Missouri's rate in 1997 compared to 1995 increased by 20 percent with the largest increase occurring among females. Overall there has been a 60 percent increase in tobacco use among Missouri high school seniors since 1991 and the gap between the state and the national rate continues to widen. Almost 90 percent of adults in Missouri who have become regular smokers, began smoking at or before age 18. It is estimated that smoking contributed to 10,930 deaths in the state in 1997 and cost Missourians approximately $2.6 billion annually in the loss of productivity and healthcare expenses.

A range of newer issues relating to children with special health care needs in Missouri is beginning to emerge:

- Data from the Department's Pediatric Nutrition Surveillance System (PNSS) reveals that almost 9 percent of all children ages 1-5, enrolled in WIC are obese. By the time children in Missouri reach adolescence (ages 13-19) over 25% of them are obese. An estimated 157,640 adolescents in Missouri are obese.
- Since 1980, there has been a dramatic increase in the number of children diagnosed with asthma in Missouri. Asthma prevalence rates among children in metropolitan St. Louis are estimated at 21% as compared to national averages of 6-8%. African Americans are 4.6 times more likely than whites to be hospitalized from asthma and 4 times more likely to die from the disease. Currently there are an estimated 87,600 children in Missouri with asthma.
- Oral health capacity and access within Missouri, has not kept pace with oral health needs of the most vulnerable citizens in this state. Improvements in oral health status have not been experienced uniformly by Missourians. A disproportionate share of oral disease is found among children and minority groups in Missouri. Those persons with the greatest percent of untreated oral diseases (who in many instances are children) are least likely to have regular dental visits, and lack access to dental care. These disparities are compounded by the almost non-existence of dentists in Missouri willing to participate in Medicaid which does not adequately compensate dentists in this state. Only about 30 percent of those who are Medicaid eligible in Missouri have visited a dentist. Like other parts of the nation, there are less than 5 pediatric dentists per 100,000 children in Missouri.
- Estimates of children with special health care needs in this state range from 251,669 or 18% to 349,540 (25%) children in the population. As increasing numbers of these children are integrated into mainstream plans such as the State Children's Health Insurance Program, some Title V funds are being redirected from payments of direct services to population based efforts for greater impact upon CSHCN health status. For example, the MCH and Missouri School-Age Children's Health Services contracts now identify CSHCN target groups and receive Title V support.

Health service gaps, system constraints and strengths and weaknesses of the service system are described in sections 3.1.2.2 through 3.1.2.5.

3.1.2.2 Direct Health Care Services

In Missouri, the advent of managed care, the introduction of the Consolidated Health plan for state employees, the shift of Medicaid from fee for service to managed care and the recent enactment of the State Children's Health Insurance Program (SCHIP) have accelerated the integration of delivery networks and reimbursement systems at regional and local levels. Missouri has been shifting its Medicaid population into managed care incrementally, beginning in more populous regions, with a goal of statewide coverage in the next five to ten years. Since July 1998, Medicaid has served the aged, disabled, Supplemental Security Income (SSI) populations, children in state custody, women up to two years after pregnancy, and infants/children up to 19 years of age up to 300% of the Federal poverty level who meet other qualifications. Missouri's 1115 waiver amendment, which went into effect in July 1998, seeks to coordinate MC+, fee-for-service Medicaid, and SCHIP to expand eligibility and coverage for these groups and "move approximately 72,000 children and 60,000 adults from the *uninsured* into the *insured* category, focusing on preventive care. MC+ is only part of Missouri's efforts to increase health care coverage. Since its inception in 1998, the State Children's Health Insurance Program has enrolled over 55,000 children with the goal of enrolling 72,000 to 75,000 children by 2000. Outreach efforts to enroll children in Missouri's SCHIP initiative, are coordinated by the Department of Social Services with support from the Missouri Department of Health.

The state Medicaid agency originally contracted with ten managed care organizations (MCOs), covering mainly the more populous areas in Missouri. Of these organizations, one is a Medicaid only plan treating approximately one third of the state's MC+ enrollees while the others serve a significantly lower proportion of Medicaid patients. In 1997, two of the ten MCOs did not re-bid at the end of their contracts. In the Fall of 1998, another plan pulled out of the northwestern corner of the state, a rural region. Currently, MC+ regions in Missouri, can be depicted as follows on page 60

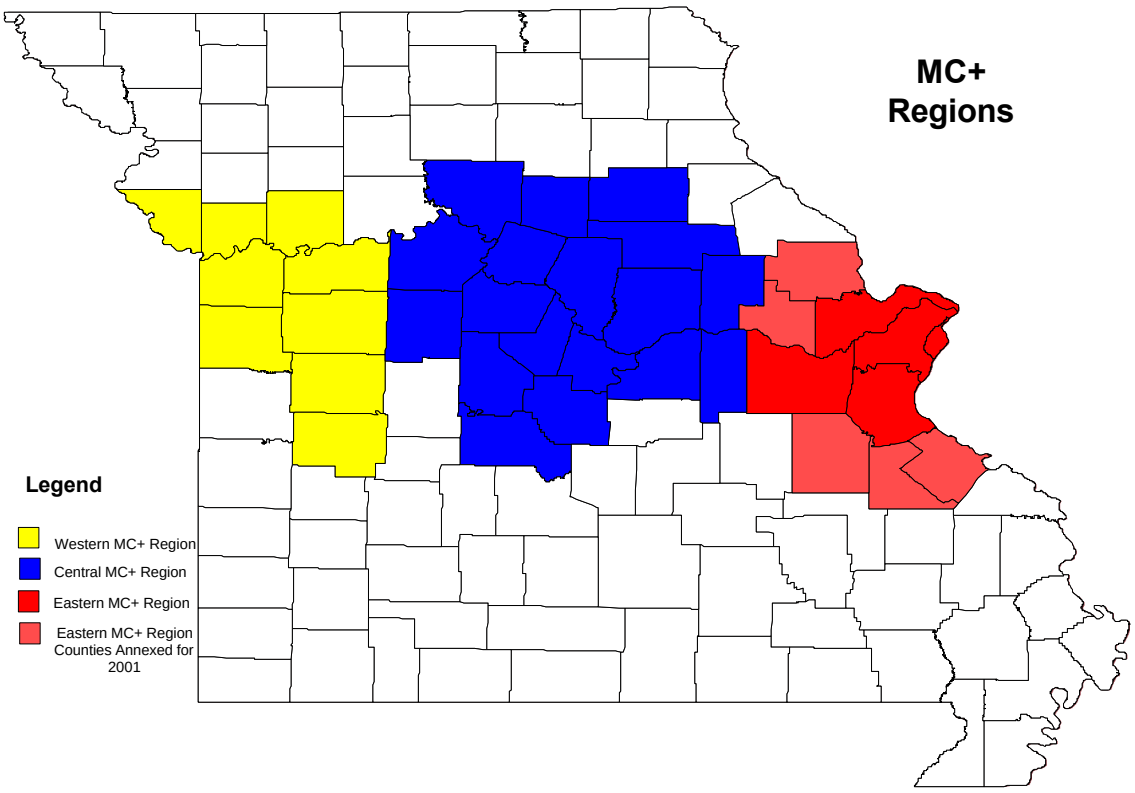
An analysis of MCH systems in transition and development in Missouri by levels of service in the MCH pyramid indicates that managed care has been the primary catalyst for change in MCH systems that deliver direct care. Managed care penetration in Missouri is consistent with national averages. As of the early part of 1997, slightly over 25% of Missouri's total population were enrolled in health maintenance organizations. In the early part of 1997, Missouri passed managed care consumer

protection legislation (House Bill 335) that holds health plans in the state to specific standards. The provisions of this legislation, include a ban on "gag clauses," mandated coverage for emergency care, and grievance procedures for managed care enrollees.

Missouri is one of the first and one of the few states in the country to have a state-sponsored purchasing alliance, the Missouri Consolidated Health Care Plan (MCHCP). MCHCP is a stand-alone state entity with its own board of trustees. As of February 1998, MCHCP negotiated coverage for more than 137,000 state and other public employees, retirees, and their dependents.

With the growing market penetration of MC+ plans, MCHCP plans, the advent of the State Children's Health Insurance Program and private sector MCOs, the population groups supported by Title V funding are increasingly being integrated into managed care networks. This would indicate a growing role for managed care networks in the delivery and assurance of essential services for MCH population groups and a somewhat diminished role for hospitals and more traditional networks although physicians continue to be an important player in emerging delivery systems. Hospitals in metropolitan markets such as St. Louis, Kansas City and Central Missouri, are rapidly merging their facilities and services. Pediatric inpatient units have all but disappeared with more and more pediatric specialty services being provided on an outpatient basis.

Increasingly, the personal (direct) services once delivered through local public health agencies are being delivered by public sector managed care plans. However, the evolution of managed care networks in Missouri has done little if anything to ameliorate the shortage of key MCH providers in some regions of this state. As the following map would suggest, the concentration of MC+ plans along the I-70 corridor may have compounded the shortage of pediatricians, obstetricians, and family physicians in the rural sectors of this state. There are no longer any managed care plans in the Northwestern region serving MC+ clients and efforts to identify managed care plans in the Southwestern region collapsed in 1998. Partially as a result of the concentration of MCOs in urban metropolitan areas of Missouri, growing numbers of practitioners are hesitant to locate in sparsely populated areas of the state. They fear there are not enough "covered lives" in rural areas for their practices to survive. There continues to be a fundamental geographical disparity of MCH delivery capacity in Missouri coupled with the lack of adequate provider financial incentives at the local, state and federal levels to lessen that disparity in rural areas.



3.1.2.3 Enabling Services

Enabling services for MCH populations in Missouri, allow or provide access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of the Medicaid, WIC and education systems. These services are especially required for the low income, disadvantaged, geographically or culturally isolated and to support those with special and complicated health needs.

The number of children receiving Medicaid in Missouri increased by 18.4 percent from 1994 to 1999, while the child population during this time period increased by about 2.1 percent. This represents an increase of almost 62,000 children eligible for Medicaid. About 24 percent of children were eligible for Medicaid in 1992 versus approximately 28% in 1999.

There are 20 counties in which more than one-third of all the children are Medicaid eligible. There are 26 counties in which there has been a 50 percent or greater

increase in the number of Medicaid eligible children. However, some of these are relatively affluent middle-class counties such as Osage, Christian, Webster, and Lincoln where a fairly low rate of eligibility in 1992 and only a modest increase translates into a large percentage increase. Many of the new jobs being created in Missouri, do not provide health insurance benefits. It is important to note that a large percentage of Medicaid-eligible persons reside in the two major metropolitan areas of the state. More than 40 percent of all Medicaid eligible children live in St. Louis City or County and in Jackson County (Kansas City). The eligible enrollment for Medicaid has greatly expanded due to the Missouri Medicaid 1115 Waiver Amendment that was enacted in 1998. That amendment expands managed Medicaid coverage to 91,000 eligible low-income children and extends family planning coverage from the current 60 days to 2 years for 44,000 eligible low-income new mothers. This amendment will build on the MC+ program by focusing on children and adults leaving welfare for work. It supports families moving from welfare into jobs and supports working families by providing MC+ coverage to 80,000 eligible low-income uninsured working parents.

There are far reaching implications of welfare reform in Missouri. As increasing numbers of mothers of young children enter the workforce, out-of-home care becomes a necessity. Of particular concern is data revealing that many counties with the highest levels of welfare dependency are also counties with the lowest levels of known child care capacity. The capacity of licensed child care facilities in Missouri is far from adequate in meeting current estimated need in most counties, let alone additional need due to the entry of welfare recipients into the work force.

Although the rate at which some Title V clients in Missouri are being integrated within managed care plans is accelerating, there will continue to be large pockets of high risk persons in MCH population groups that no managed care organization (network) is willing to totally absorb. The intensive specialized care required by children with special health care needs increases the financial risk of MCOs. While many believe that chronic conditions in children are rare, state and national data indicates that an estimated 20% of all children have a chronic physical or mental condition requiring services that typically extend beyond those needed by healthy children. It is also estimated that 31% of all children in Missouri have one or more chronic conditions at some time during their youth and 6% of Missouri's children have a severe chronic illness.

The question that must be addressed by the Missouri Title V agency, is how to *enable* access to essential MCH services for high risk women and children while the

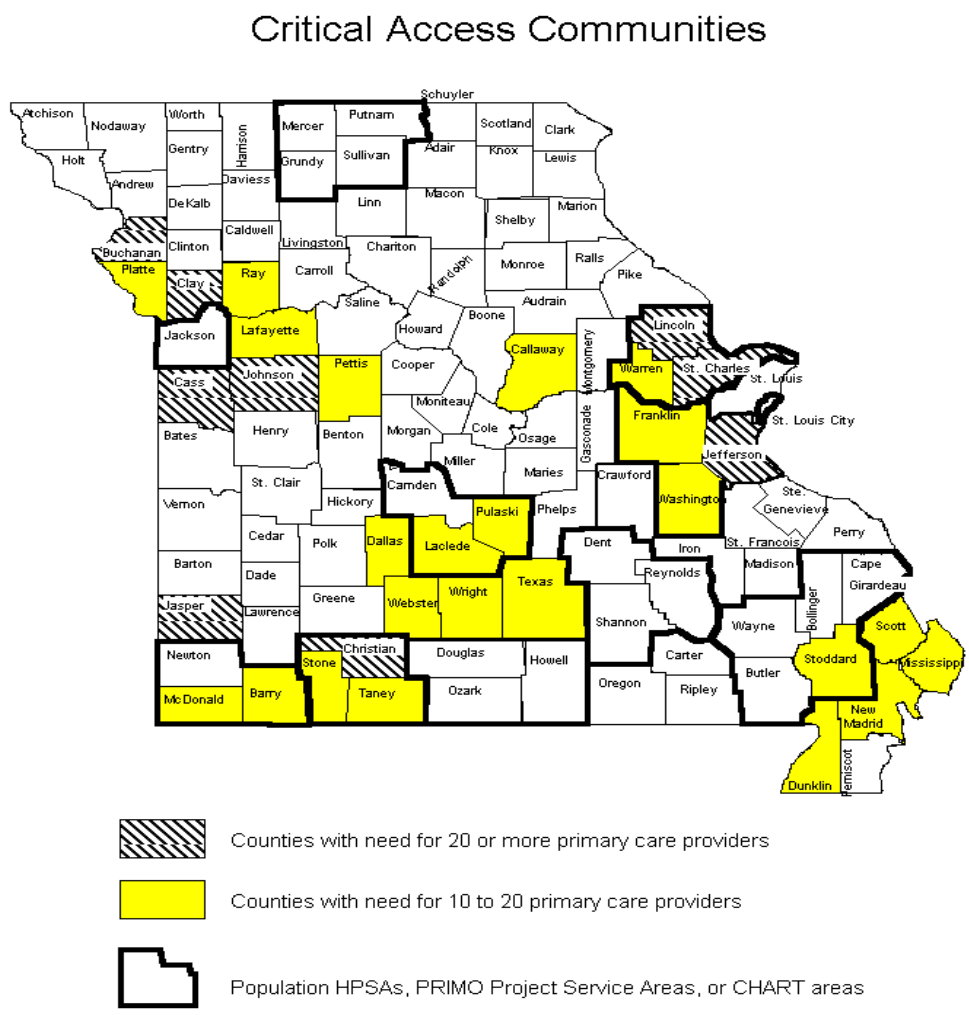
transition from a “fee for service delivery system” to more integrated managed care delivery networks occurs.

In Missouri, health outreach workers and “service coordinators” give and collect information from individual persons to find cases, determine eligibility for services, refer and participate in the authorization of services, and follow-up to assure aftercare is given. Service coordinators are part of the primary care team in assuring continuity of care; and centering attention on the family unit in order to serve each individual member more effectively. They are part of a community’s outreach and advocacy network in expanding and assuring services at a time when case managers in MCOs are under mounting pressure to limit that access in some instances. The network of service coordinators supported through the Bureau of Special Health Care Needs, will continue to coordinate essential MCH services that allow or provide for access to and the derivation of benefits from, the array of basic health care services .

Coordination for better access to essential MCH services, is becoming a greater challenge for Missouri’s Title V agency due to the documented shortages of primary care physicians, pediatricians, and obstetricians in many of the rural regions of this state. Those shortages are worsening in the extreme northern, southeastern and southcentral regions of Missouri. Medical specialists serving children with special health care needs are non-existent in many of those rural areas. The growing shortage of dentists to serve the dental needs of children (particularly low-income children) in virtually all regions of Missouri, is also well documented. Current data is not available to document the distribution and scope of services delivered by audiologists, occupational therapists, physical therapists and speech/language therapists to children with special health needs. Schools in Missouri are under growing pressure to find more resources to support more of these needs in the school setting.

BSHCN local area offices are interfacing with local public health agencies to provide and obtain referrals. This effort will be continued in order to strengthen the local networks providing services to all children with special health care needs. Access to specialty inpatient services in the non-managed care rural areas has been identified as an issue for program participants in FFY99. Review of policy and outreach efforts to selected facilities is under consideration. Early intervention services are provided through the IDEA (Part C) First Steps System administered through the BSHCN. The Children with Special Health Care Needs (CSHCN) program provides early intervention for those that do not qualify for First Steps and those that meet CSHCN program

requirements. These services would not otherwise be accessible or available to Missouri's special needs populations. CSHCN service coordination links necessary services with other state and local agencies. The BSHCN, through an interagency agreement with the Department of Social Services, provides administrative case management for CSHCN who participate in Medicaid's Healthy Children and Youth program. The BSHCN works with the Bureau of Dental Health's mobile dental unit program to assure children with special health care needs obtain primary dental care. The following map illustrates geographic areas in Missouri that are under served in Missouri because of a lack of primary medical/health services:



HPSA - Health Professional Shortage Area

PRIMO – Primary Care Resources Initiative for Missouri

CHART – Community Health Assistance Resource Team

3.1.2.4 Population-Based Services

Population based interventions are aimed at disease prevention and health promotion that affect an entire population and extend beyond medical treatment by targeting underlying risks such as tobacco, drug, and alcohol use; diet and sedentary lifestyles; and environmental factors. Population based services can be contrasted with personal health services which are delivered in one on one situations. Selected population based programs that are supported totally or in part by Title V funding and administered by the Missouri Department of Health, can be summarized as follows:

- Home Visitation Programs
- Newborn Screening
- Immunizations
- Child Care Facility/Provider Regulation
- Dental Sealant Program
- Community Water Fluoridation
- Injury Control
- School Aged Children's Health Services Program
- Prevention of Child Abuse
- Abstinence Only Education
- TEL-LINK Referral Services
- Sexual Assault Forensic Evaluation-Child Abuse Resource and Education (SAFE-CARE) Network

The Department of Health through its Center for Local Public Health Services, also continues to maintain strong collaborative and contractual relationships with 115 local public health agencies in Missouri. Local public health agencies in Missouri support many population based environmental health services that protect the health status of MCH population groups:

- Milk and Food Inspection
- Communicable Disease Control
- Insect and Rodent Control
- Water Supply Safety
- Waste Disposal Sanitation

Finally, the Department of Health and other state agencies participating on the Healthy Missourian's Sub-Cabinet, are evaluating programs and interventions that impact MCH outcomes. Many of the interventions this Sub-Cabinet is focusing on to improve these outcomes (Show Me Results), such as education and counseling to reduce unintended pregnancies, are broad population based interventions.

3.1.2.5 Infrastructure Building Services

In Missouri, it is important to maintain availability of and access to core MCH services while contraction and integration of the health care delivery system in this state accelerates. Increased insurance coverage for MCH population groups will not in and of itself guarantee the availability of or the access to these essential services. Like other states, Missouri is continually assessing what is the appropriate mix of direct health care, enabling and population based services to assure accessible networks of care for maternal and child health groups. The Missouri Department of Health is also supporting the incremental development of public sector managed care plans with these system characteristics:

- Phased in Medicaid managed care;
- Maximum allowable travel times and distances for managed care organization members
- Incorporation (where possible) of rural health clinics and local public health agencies in managed care networks;
- Incentives for MCOs to establish contracts with providers in contiguous counties and institute satellite clinics and mobile units
- Allowance for plan members to go out of state for care in areas with less extensive provider networks
- Survey MCO members to assess levels of satisfaction with services received and public results in "report card" like format for the general public;
- Adequate scope and depth of key MCH providers participating in managed care networks:
  > Pediatricians
  > Obstetricians
  > Nurse Practitioners
  > Medical specialties to support children with special health needs

The Missouri Department of Health, and the Division of Maternal, Child and Family Health continues to maintain collaborative relationships with state and local branches of the American Academy of Pediatrics, the American Academy of Family Practice, and American College of Obstetrics and Gynecology, and family and parent advocacy organizations such as the Children's Trust Fund and *Kids Count.* Participating provider agreements of the Bureau of Special Health Care Needs, encompass "major providers of health and health-related services" for children with special needs as shown below:

Barnes/Jewish Hospital
216 South Kingshighway Blvd.
St. Louis, MO 63110
314/454-7000

Bethesda General Hospital
3655 Vista Avenue
St. Louis, MO 63110
314/772-9200

Boone Hospital Center
1600 East Broadway
Columbia, MO 65201
573/875-4545

Children's Mercy Hospital
24th & Gillham
Kansas City, MO 64108
816/234-3000

Columbia Regional Hospital
404 Keene Street
Columbia, MO 65201
573/875-9000

Doctors' Park Surgery
621 Pine Boulevard
Poplar Bluff, MO 63901
573/686-4111

Doctors Regional Medical Center
21 Pine Boulevard
Poplar Bluff, MO 63901
573/686-4111

Freeman Oak Hill Health System
1102 West 32nd Street
Joplin, MO 64804
417/623-2801

Bothwell Regional Health Center
601 East 14th, P. O. Box 1706
Sedalia, MO 65301
660/826-8833

Capital Region Medical Center
1125 Madison
Jefferson City, MO 65101
573/635-7100

Cardinal Glennon Children's Hospital
1465 South Grand Boulevard
St. Louis, MO 63104
314/268-2727

Jefferson Memorial Hospital
PO Box 350 Hwy 61 South
Crystal City, MO 63019
314/933-1000

Lester E. Cox Medical Center
1423 North Jefferson Street
Springfield, MO 65802
417/269-6000

Lucy Lee Hospital
2620 North Westwood Boulevard
Poplar Bluff, MO 63901-2341
573/785-7721

Missouri Delta Medical Center
1008 North Main
Sikeston, MO 63801-5099
573/471-1600

Missouri Rehabilitation Center
600 North Main
Mt. Vernon, MO 65712
417/466-3711

Ellis Fischel Cancer Center
115 Business Loop 70 West
Columbia, MO 65203
573-882-2100

Hannibal Reg. Health Care Center, Inc
109 Virginia Street
Hannibal, MO 63401
573/248-1300

Heartland Hospital - East
5325 Faraon Street
St. Joseph, MO 64506
816/271-6000

Heartland Hospital – West
801 Faraon Street
St. Joseph, MO 64501
816/271/7111

Independence Regional Health Center
1509 West Truman Road
Independence, MO 64050
816/836-8100

Research Medical Center
2316 East Meyer Boulevard
Kansas City, MO 64132
816/276-4000

SSM Rehabilitation Institute
6420 Clayton Road #600
St. Louis, MO 63117-1811
314/994-0157

Southeast Missouri Hospital
1701 Lacey
Cape Girardeau, MO 63701
573/651-5503

St. Francis Medical Center
211 St. Francis Drive
Cape Girardeau, MO 63703-8399
573-339-6980

St. John's Regional Medical Center
2727 McClelland Boulevard
Joplin, MO 64804
417/781-2727

Oak Hill Hospital
932 East 34th Street
Joplin, MO 64804
417/623-4640

Pemiscot County Memorial Hospital
Box 489
Hayti, MO 65401
573/359-1372

Phelps County Regional Medical Center
1000 West 10th Street
Rolla, MO 65401
573/364-3100

Regional Ear, Nose & Throat
1965 South Fremont, Suite 1940
Springfield, MO 65804
417/887-5750

Rehabilitation Institute
3011 Baltimore Ave.
Kansas City, MO 64108
816/756-2250

St. Louis University Medical Center
3635 Vista at Grand
St. Louis, MO 63110
314/268-5027

St. Luke's Hospital
232 South Woodsmill Road
Chesterfield, MO 63017
314/434-1500

St. Luke's Hospital
4400 Wornall Road
Kansas City, MO 64111-9000
816/932-2102

St. Mary's Health Center-Jefferson City
100 St. Mary's Medical Plaza
Jefferson City, MO 65101
573/635-7642

Surgery Center of Springfield
1350 East Woodhurst
Springfield, MO 65804
417/887-5243

St. John's Mercy Medical Center
615 South New Ballas Road
St. Louis, MO 63141
314/569-6500

St. John's Regional Health Center
1235 East Cherokee Street
Springfield, MO 65804
417/885-2000

St. Joseph Health Center
1000 Carondelet Drive
Kansas City, MO 64114
816/942-4400

St. Louis Children's Hospital
#1 Children's Place
St. Louis, MO 63110-1077
314/454-6184

St. Louis Regional Medical Center
5535 Delmar
St. Louis, MO 63112
314/879-6211

University of MO Hospital & Clinics
W143 Hospital Patient Accounts
One Hospital Drive
Columbia, MO 65212
573/882-1183

Doctor's Park Surgery
30 Doctors Park
Cape Girardeau, MO 63701
573/334-9606

ENT Urology Surgical Care
5301 Faraon, Suite 220
St. Joseph, MO 64506
816/364-2772

Missouri Surgery Center
300 S. Mount Auburn
Suite #200
Cape Girardeau, MO 63703
573/339-7575

Trinity Lutheran Hospital
3030 Baltimore
Kansas City, MO 64108
816/751-2935

Truman Medical Center-East
7900 Lee's Summit Road
Kansas City, MO 64139
816/373-4415

Truman Medical Center-West
2301 Holmes Street
Kansas City, MO 64108
816/556-3057

Twin Rivers Regional Medical Center
1301 First Street
Kennett, MO 63857
573/888-4522

University of Kansas Medical Center
39th & Rainbow
Kansas City, KS 66103
913/588-5000

Springfield Clinic Ambulatory
Head & Neck Surgery Center
1965 South Fremont, Suite 1940
Springfield, MO 65804
417/887-5750

Surgery Center Springfield
1350 E. Woodhurst
Springfield, MO 65804
417/887-5243

The Surgery Center
802 North Riverside Road, Suite 115
St. Joseph, MO 64507
816/364-5030

State program collaboration with other state agencies and private organizations is realized through interagency agreements that allow:

- Receipt of referrals from the Disability Determination Unit of Social Security Administration
- Provision of administrative case management for Medicaid recipients requiring services for children with special health care needs
- Provision of administrative case management for Medicaid special health care needs recipients transitioning into adult programs
- Provision of service coordination of early intervention services for eligible children with special health care needs
- Provision of funding for dental services for children with special health care needs

The Division of Maternal, Child and Family Health maintains interagency collaboration for needs assessment at the community level by participating in advisory groups, subcommittees, work groups and associations. Example advisory groups and councils participated in include:

- MC+ Quality Assurance and Improvement
- Head Injury Advisory Group
- Genetics Advisory Group
- Region VII State Planning Team
- Council for Inclusive Child Care
- Local Interagency Coordinating Councils
- State Interagency Coordinating Councils

State CSHCN support for communities occurs through contractual relationships with providers and treatment centers to deliver services to CSHCN populations and through community based service coordination which links families with providers, state agencies, and other community entities supporting services for children with special health care needs in Missouri.

Coordination of health components of community-based systems at the community level occurs through the Missouri Department of Health's service coordination network. As a result of interagency agreements with the Department of Social Services and the Department of Elementary and Secondary Education, the Department of Health's service coordinators in many instances present a single source of care coordination at the local level for persons or families requiring coordination and referral to community based services. The Division of Maternal, Child and Family

Health, through locally based offices, provides service coordination as a component of the health care provided to children with special health care needs. Service coordination helps find needed services otherwise unavailable, as well as prevents duplication of services by multiple entities. The MCFH service coordination system optimizes resource use at the community level by coordinating appropriate providers and state agencies to most effectively meet the needs of the child and family.

The Missouri Department of Health is cultivating partnerships with managed health care networks, health plans and other agencies. The Department has specialized knowledge and experience in working with low-income maternal and child groups which both managed care organizations and other state agencies may benefit from. These partnerships will enable Missouri's Title V agency to:

- Offer technical assistance to managed care organizations to help them provide services to at-risk Medicaid beneficiaries;
- Help guide policy and implementation decisions;
- Develop standards for and assure the quality and availability of clinical and supporting services; and
- Ensure the collection and use of necessary data to monitor the effects of Medicaid managed care on access satisfaction, and health outcomes.

An example of this focused specialized knowledge is the Center for Health Information and Management Epidemiology (CHIME) analysis of how Medicaid and non-Medicaid MCH populations compare against quality indicators for those populations. Excerpts from a recent analysis are included as part of this five year Title V need/capacity assessment:

In the Missouri Medicaid population, managed care is used primarily by children and women of childbearing age and that is why we have focused on maternal and child health indicators. The Missouri Department of Social Services, Division of Medical Services operates a statewide MC+ quality assessment and improvement committee made up of managed care plan members, physicians, nurses and others interested in health care management.

In summary, the key maternal and child health indicators while showing some modest improvements, do not show any great trend shifts since Medicaid managed care went into effect in September 1995. Generally, trends previously established are continuing as the quality of care appears to be remaining stable.

Trends in Missouri Medicaid Quality Indicators: Missouri 1994 – 1998

MEDICAID	*1994*	*1995*	*1996*	*1994*	*1998 (Prov.)*	*Percent Change 1994-1998*
Prenatal Care Began 1st trimester	71.9%	74.7%	75.8%	76.1%	76.2%	6.0
Inadequate prenatal care	23.9%	21.3%	20.2%	19.6%	18.8%	-21.4
Smoking during pregnancy	32.3%	31.8%	31.8%	32.3%	32.0%	-1.0
Spacing<18 mos since last birth	18.2%	15.3%	15.0%	15.7%	15.5%	-14.9
Repeat teen births	6.7%	6.4%	6.2%	5.9%	6.1%	-9.4
Percent of prenatals on WIC	79.8%	80.9%	82.5%	82.8%	81.5%	2.1
Asthma hospitalizations<18 per 1,000	5.7%	4.7%	4.0%	5.1%	4.5%	-21.1*
Proportion on Managed Care (MC+)	0.0%	7.3%	36.1%	60.9%	59.8%	
Non-MEDICAID						
Prenatal Care Began 1st trimester	92.0%	92.2%	92.0%	92.3%	92.4%	0.4
Inadequate prenatal care	6.5%	6.5%	6.7%	6.3%	6.1%	-6.7
Smoking during pregnancy	12.6%	12.1%	11.4%	11.3%	10.9%	-13.6
Spacing<18 months since last birth	7.9%	7.6%	7.9%	7.8%	7.5%	-5.7
Repeat teen births	0.7%	0.7%	0.7%	0.7%	0.8%	16.8
Percent of prenatals on WIC	11.1%	11.5%	12.9%	13.7%	14.2%	28.9
Asthma hospitalizations<18 per 1,000	1.4%	1.4%	1.2%	1.4%	1.1%	-21.4

*1994-1997 percent change
Note: The source of all indicators is the Missouri birth file, with the exception of asthma hospitalization<18, whose source is the Missouri patient abstract file.

The Maternal and Child Health sub-group of the Statewide MC+ QA & I group is identifying and encouraging the implementation of best practices for health plans for the key indicators. The Missouri Department of Health will continue to monitor trends in these key indicators to help ensure that quality health care is delivered to Missouri's Medicaid population.

3.2 Health Status Indicators

The primary source for health data within the state is the Center for Health Information and Management Epidemiology (CHIME). CHIME oversees the statistical

support and health care assurance activities of the Department of Health. CHIME collects, analyzes, and distributes health related information which promotes better understanding of health problems and needs in Missouri, as well as highlighting improvements and progress achieved in the general health status of Missourians. To assure uniform and consistent reporting of all Title V related data, the Division of Maternal, Child and Family Health works with CHIME to integrate the eight core health status indicators and some of the developmental health status indicators into the Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC).

MOHSAIC utilizes a data warehouse augmented with surveillance data such as births, deaths, immunization, hospital patient abstracts, cancer registry, etc. The data fields are configured to allow analytic tools to retrieve the data in an aggregated format useful for assessment and policy development purposes. Selected data from the MOHSAIC information warehouse is moved to the Missouri Department of Health's web page for external users to access.

The Department of Health's web page provides access to MCH data through the Maternal and Child Health Profiles and the Missouri Information for Community Assessment (MICA) system. The MCH Profiles are resource pages that provide information on a specific MCH indicator, including a definition of the indicator, risk factors, description of the condition, intervention strategies, state related programs, community programs and resources, contracts and grants, educational material, studies and reports and other web sites pertaining to the MCH indicator. See these sections:

- **Section 5.4 –** Core Health Status Indicator Forms
- **Section 5.5 –** Core Health Status Detail Sheets
- **Section 5.6 –** Developmental Health Status Indicator Forms
- **Section 5.7** – Developmental Health Status Detail Sheets

In addition to general MCH demographic data, the CHIME system can now aggregate key indicators by MCH life stages:

- Preconception
- Prenatal
- Deliveries
- Infant
- Child

With the data available through CHIME state and county MCH profiles and through the MICA system individuals can now graph and map many key MCH indicators that provide an informational bridge to help monitor Title V outcomes and performance measures. Those indicators include:

- Low birth weight
- Smoking during pregnancy
- Inadequate prenatal care
- Birth spacing
- Teenage births

The MCH life state profiles and selected MCH indicators generated from CHIME data systems (located on the Department's website at www.health.state.mo.us) can be summarized as follows for the state of Missouri:

Demographics MCH Profile

Demographics		Data Years	Number of Events	Rate	Significantly Different	Ranking Quintile	State Rate
Females 15-17		1997	120,400	10.1			10.1
Females 18-34		1997	627,900	52.7			52.7
Females 35-44		1997	442,800	37.2			37.2
Females 15-44 (5 yr. Change)		1992-1997	23,300	2			2
Females 15-44							
	Below FPL	1995-1997 Average	152,719	12.7			12.7
	Below 185% FPL	1995-1997 Average	352,056	29.4			29.4
	Below 300% FPL	1995-1997 Average	623,496	52			52
	Below 300% FPL Without Health Insurance	1995-1997 Average	169,200	14.1			14.1
Divorces Involving Children Under 18		1997	13,276	51.8	N/S		51.8

* Fewer than 20 events in numerator; therefore rate is unstable.
** Only Statewide Data available.

Maternal (Preconception/Family Planning) Health Profile

Preconception/Family Planning		Data Years	Number of Events	Rate	Significantly Different	Ranking Quintile	State Rate
Birth by Age of Mother							
	Under 15	1993-1997	1,023	0.3	N/S		0.3
	15-17	1993-1997	18,600	5	N/S		5
	18-19	1993-1997	33,009	8.9	N/S		8.9
	20-24	1993-1997	99,625	27	N/S		27
	25-29	1993-1997	102,294	27.7	N/S		27.7
	30-34	1993-1997	78,606	21.3	N/S		21.3
	35-39	1993-1997	30,723	8.3	N/S		8.3
	40 and Over	1993-1997	4,972	1.3	N/S		1.3
STDs							
	Chlamydia	1995-1997	30,431	854.3	N/S		854.3
	Gonorrhea	1995-1997	12,901	362.2	N/S		362.2
	Early Syphilis	1995-1997	914	25.7	N/S		25.7
Mothers Education Less Than 12 Years		1993-1997	71,606	19.4	N/S		19.4
Mother>=20% Overweight for Height		1993-1997	102,300	29	N/S		29
Mother >15% Underweight for Height		1993-1997	27,885	7.9	N/S		7.9
Live Births & Fertility Rate		1997	73,940	62.1	N/S		62.1
Live Births-5 Year Change		1992-1997	-2,065	-2.7			-2.7
Fertility Rate-5 Year Change		1992-1997	-3	-4.6			-4.6
Teen Fertility Rate Under Age 18		1993-1997	19,623	34.5	N/S		34.5
Teen Pregnancy Rate Under Age 18		1993-1997	25,900	45.6	N/S		45.6
Repeat Births Under Age 20		1993-1997	11,305	3.1	N/S		3.1
Out-of-Wedlock Births		1993-1997	120,471	32.7	N/S		32.7
Spacing Less Than 18 Months		1993-1997	23,822	11.5	N/S		11.5
Four Plus Prior Live Births		1993-1997	15,027	4.1	N/S		4.1
Induced Abortions		1993-1997	70,479	191.1	N/S		191.1
Repeat Abortions		1993-1997	26,703	37.9	N/S		37.9
Induced Abortions Mother Under Age 18		1993-1997	6,110	23.6	N/S		23.6
Unintended Deliveries (Vital Records Definition)		1997	24,478	32.9	N/S		32.9

* Fewer than 20 events in numerator; therefore rate is unstable.

Maternal (Prenatal) Health Profile by Race

Prenatal	Data Years	Number of Events	Rate	Significantly Different	Ranking Quintile	State Rate
Care Began First Trimester	1996-1997	124,217	84.1	N/S		84.1
Late Care (2nd-3rd Trimester Entry)	1996-1997	19,132	13	N/S		13
No Prenatal Care	1996-1997	1,453	1	N/S		1
Inadequate Prenatal Care	1996-1997	16,732	11.7	N/S		11.7
Prenatal Medicaid	1997	31,130	42.1	N/S		42.1
Prenatal WIC	1997	29,709	40.2	N/S		40.2
Prenatal Food Stamps	1997	13,625	19.1	N/S		19.1
Weight Gain <15 lbs.-Term Singleton	1993-1997	23,613	7.4	N/S		7.4
Weight Gain>=45 lbs.-Term Singleton	1993-1997	50,967	16.1	N/S		16.1
Mother Smoked During Pregnancy	1997	14,409	19.5	N/S		19.5

* Fewer than 20 events in numerator; therefore rate is unstable.

Infant Health Profile

	Data Years	Number of Events	Rate	Significantly Different	Ranking Quintile	State Rate
Morbidity						
Preterm (<37 Weeks Gestation)	1993-1997	36,392	9.9	N/S		9.9
Low Birth Weight	1993-1997	28,001	7.6	N/S		7.6
Low Birth Weight & Term	1993-1997	10,812	3.3	N/S		3.3
Very Low Birth Weight	1993-1997	4,878	1.3	N/S		1.3
Small for Gestational Age	1993-1997	37,610	10.5	N/S		10.5
Birth Defects	1993-1996	11,742	4	N/S		4
Neural Tube Defects (NTD)	1993-1996	218	7.4	N/S		7.4
Utilization						
Very Low Birth Weight Cared for in Level III Centers	1993-1997	3,805	80.1	N/S		80.1
Infants Participating in WIC	1997	40,730	55.1	N/S		55.1
Infants on Medicaid	1997	33,306	45	N/S		45
Mortality						
Neonatal Deaths	1988-1997	4,064	5.4	N/S		5.4
Perinatal Deaths	1988-1997	8,861	11.6	N/S		11.6
Post Neonatal Deaths	1988-1997	2,550	3.4	N/S		3.4
Infant Deaths	1988-1997	6,614	8.7	N/S		8.7
Sudden Infant Death Syndrome (SIDS)	1988-1997	1,141	1.5	N/S		1.5

*Fewer than 20 events in numerator; therefore rate is unstable.

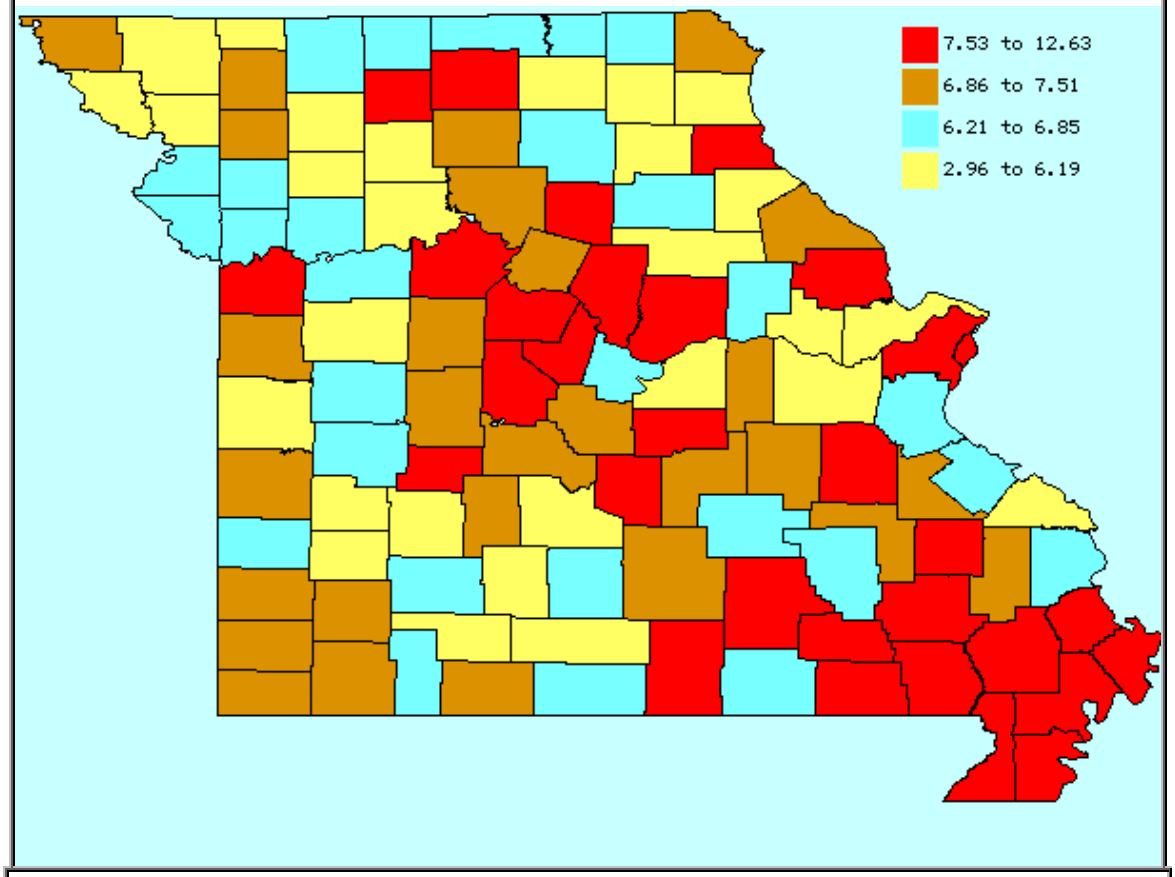
Child Health Profile

		Data	Number		Significantly	Ranking	State
General/Poverty and Utilization Under 19		**Years**	**of Events**	**Rate**	**Different**	**Quintile**	**Rate**
Without Health Insurance		1995-1997 Average	189,559	13.3			13.3
	& Below 100% FPL	1995-1997 Average	56,723	4			4
	& Below 300% FPL	1995-1997 Average	161,667	11.3			11.3
Probable Cause Child Abuse/Neglect		1995-1997	49,889	15.6	N/S		15.6
Ages 1-14 Population Estimates							
	Ages 1 - 4	1997	292,860	5.4			5.4
	Ages 5 - 14	1997	791,300	14.6			14.6
Uninsured Outpatients Ages 1-14		1998	40,453	11.0			11.0
Uninsured Inpatients Ages 1-14		1998	1,522	5.6			5.6
Injury Hospitalizations		1994-1997	507,946	11801.8	N/S		11801.8
Asthma Hospitalizations		1994-1997	9,932	2.3			2.3
WIC Participation Ages 1 - 4		1997	89,179	30.5	N/S		30.5
Lead Testing Ages 0-6		1999	46,715	10.6			10.6
Blood Lead Elevations >9mg/dL Ages 0-6		1999	5,092	10.9			10.9
Total Deaths		1987-1997	3,610	31.8	N/S		31.8
Motor Vehicle Deaths		1987-1997	709	6.3	N/S		
Five Leading Causes of Death							
	1) Unintentional Injuries	1987-1997	1,557	13.7	N/S		13.7
	2) Cancer	1987-1997	357	3.1	N/S		3.1
	3) Birth Defects	1987-1997	304	2.7	N/S		2.7
	4) Homicides	1987-1997	262	2.3	N/S		2.3
	5) Heart Disease	1987-1997	136	1.2	N/S		1.2
Ages 15-19 Population Estimates							
	Ages 15 - 17	1997	248,300	4.6			4.6
	Ages 18 - 19	1997	153,900	2.8			2.8
Uninsured Outpatients Ages 15-19		1998	33,620	22.1			22.1
Uninsured Inpatients Ages 15-19		1998	1,830	7.1			7.1
Injury Hospitalizations		1994-1997	257,013	16913.2	N/S		16913.2
Asthma Hospitalzations		1994-1997	1,089	0.7			0.7
STDs							
	Chlamydia	1995-1997	16,733	1421.1	N/S		1421.1
	Gonorrhea	1995-1997	8,825	749.5	N/S		749.5
	Syphilis	1995-1997	199	16.9	N/S		16.9
Total Deaths		1987-1997	4,103	103.2	N/S		103.2
Motor Vehicle Deaths		1987-1997	1,715	1,715	N/S		43.1
Five Leading Causes of Death							
	1) Unintentional Injuries	1987-1997	2,114	53.1	N/S		53.1

	2) Homicide	1987-1997	753	18.9	N/S		18.9
	3) Suicide	1987-1997	516	13	N/S		13
Five Leading Causes of Death		Data Years	Number of Events	Rate	Significantly Different	Ranking Quintile	State Rate
	4) Cancer	1987-1997	149	3.7	N/S		3.7
	5) Heart Disease	1987-1997	102	2.6	N/S		2.6

* Fewer than 20 events in numerator; therefore rate is unstable.
** Only Statewide Data available.

Missouri Births
Percents - Low Birth Weight
Age of Mother: (All Ages) Marital Status: (All Mothers) Medicaid Status (All Mothers)
Year: 1995,1996,1997,1998



Rate per 100 - denominator - All Births

County	Number	Percent	County	Number	Percent	County	Number	Percent
Adair	67	6.0	Greene	837	6.8	Ozark	27	6.6
Andrew	36	5.3	Grundy	39	7.5	Pemiscot	191	12.6
Atchison	19	7.5	Harrison	25	6.6	Perry	42	4.6
Audrain	76	6.0	Henry	62	6.3	Pettis	151	7.2
Barry	137	7.4	Hickory	26	8.5	Phelps	122	6.9
Barton	46	6.4	Holt	11	5.5	Pike	58	7.4
Bates	39	4.8	Howard	30	7.0	Platte	240	6.3

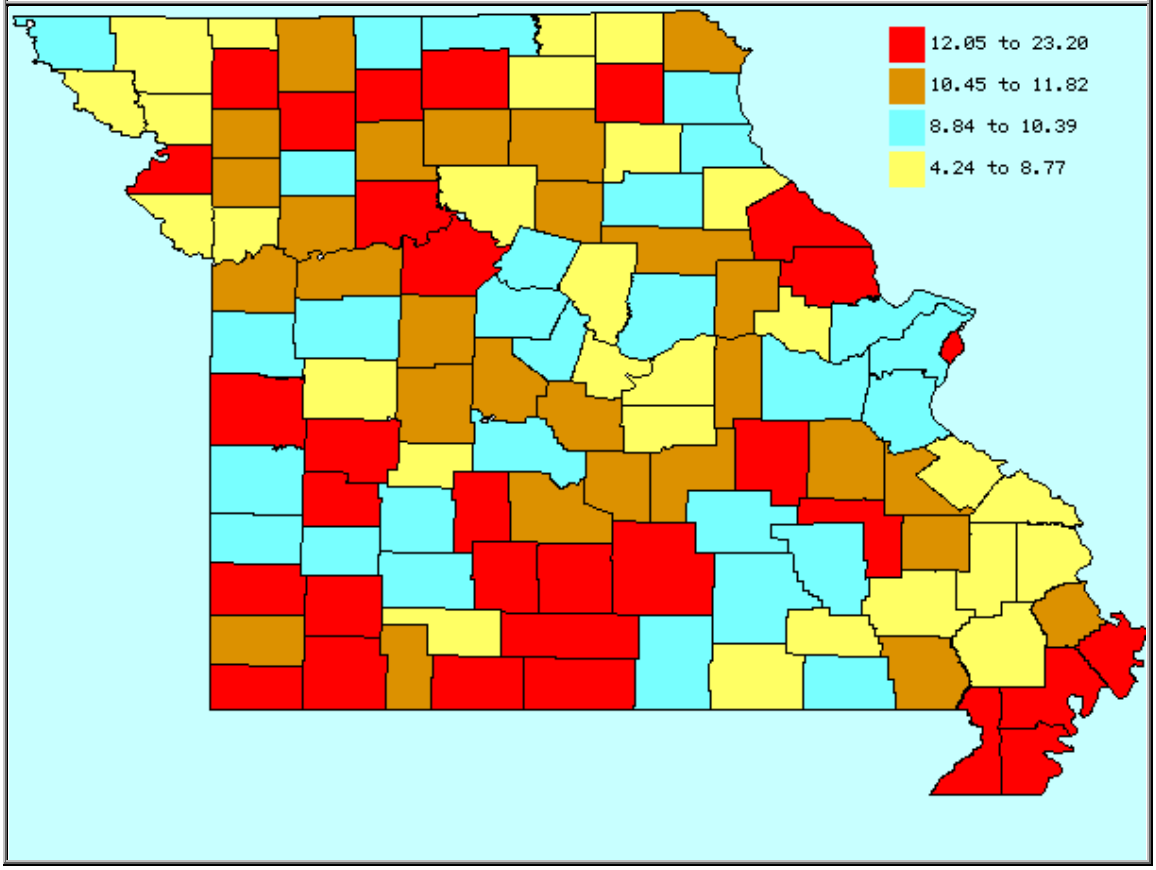
Missouri Births								
Percents - Low Birth Weight								
Age of Mother: (All Ages) Marital Status: (All Mothers) Medicaid Status (All Mothers)								
Year: 1995,1996,1997,1998								
Rate per 100 - denominator - All Births								
County	Number	Percent	County	Number	Percent	County	Number	Percent
Benton	45	7.1	Howell	145	7.6	Polk	70	5.3
Bollinger	35	7.1	Iron	40	7.3	Pulaski	207	8.6
Boone	558	8.1	Jackson	3296	8.6	Putnam	16	6.8
Buchanan	300	6.8	Jasper	417	6.9	Ralls	19	5.3
Butler	181	8.6	Jefferson	737	6.8	Randolph	141	11.0
Caldwell	22	5.4	Johnson	148	5.7	Ray	77	6.5
Callaway	144	7.9	Knox	6	3.0	Reynolds	20	6.8
Camden	90	7.0	Laclede	105	6.2	Ripley	54	7.9
Cape Girardeau	215	6.8	Lafayette	98	6.5	St. Charles	907	5.8
Carroll	25	5.1	Lawrence	140	7.5	St. Clair	25	6.5
Carter	28	8.3	Lewis	25	4.7	St. Francois	190	7.2
Cass	297	6.9	Lincoln	153	7.9	St. Louis County	3986	7.6
Cedar	30	5.1	Linn	48	6.9	St. Louis City	2799	12.1
Chariton	22	7.2	Livingston	44	6.2	Ste. Genevieve	50	6.8
Christian	162	6.0	McDonald	93	7.1	Saline	101	8.9
Clark	23	7.0	Macon	54	6.8	Schuyler	13	6.2
Clay	605	6.2	Madison	43	7.6	Scotland	19	6.5
Clinton	65	6.8	Maries	35	9.1	Scott	227	9.7
Cole	240	6.7	Marion	128	8.1	Shannon	36	9.4
Cooper	67	8.6	Mercer	10	6.2	Shelby	18	5.8
Crawford	90	7.4	Miller	90	7.3	Stoddard	108	8.5
Dade	19	5.3	Mississippi	89	11.0	Stone	82	6.6
Dallas	57	7.1	Moniteau	58	7.8	Sullivan	33	9.0
Daviess	18	4.0	Monroe	29	6.8	Taney	137	7.0
DeKalb	29	7.4	Montgomery	34	6.4	Texas	79	7.4
Dent	46	6.6	Morgan	67	7.7	Vernon	80	7.5
Douglas	36	6.1	New Madrid	101	9.2	Warren	67	5.5
Dunklin	175	9.3	Newton	198	7.1	Washington	102	8.6
Franklin	303	6.0	Nodaway	36	4.2	Wayne	63	10.9
Gasconade	47	7.0	Oregon	30	6.3	Webster	107	6.1
Gentry	22	6.9	Osage	26	3.9	Worth	5	5.1
State of Missouri	22701	7.7				Wright	63	6.4

Missouri Births

Percents – Spacing less than 18 Months

Age of Mother: (All Ages) Marital Status: (All Mothers) Medicaid Status (All Mothers)

Year: 1995,1996,1997,1998



Rate per 100 – denominator - All mothers who have had a live birth

County	Number	Percent	County	Number	Percent	County	Number	Percent
Adair	50	8.0	Greene	705	10.4	Ozark	33	14.2
Andrew	35	8.3	Grundy	42	13.8	Pemiscot	216	23.2
Atchison	14	9.5	Harrison	25	11.6	Perry	38	7.2
Audrain	82	10.7	Henry	47	8.8	Pettis	129	10.8
Barry	138	12.1	Hickory	12	6.8	Phelps	105	10.4
Barton	44	9.9	Holt	7	6.2	Pike	60	12.3
Bates	57	12.1	Howard	23	9.2	Platte	163	7.9
Benton	40	11.3	Howell	112	10.2	Polk	74	9.7
Bollinger	18	6.3	Iron	49	15.4	Pulaski	159	11.6
Boone	305	8.2	Jackson	2457	11.6	Putnam	12	9.2
Buchanan	307	12.2	Jasper	443	12.7	Ralls	16	7.4
Butler	125	11.7	Jefferson	588	9.8	Randolph	79	10.9
Caldwell	22	8.9	Johnson	144	10.1	Ray	79	11.6
Callaway	91	9.0	Knox	17	13.9	Reynolds	16	9.2

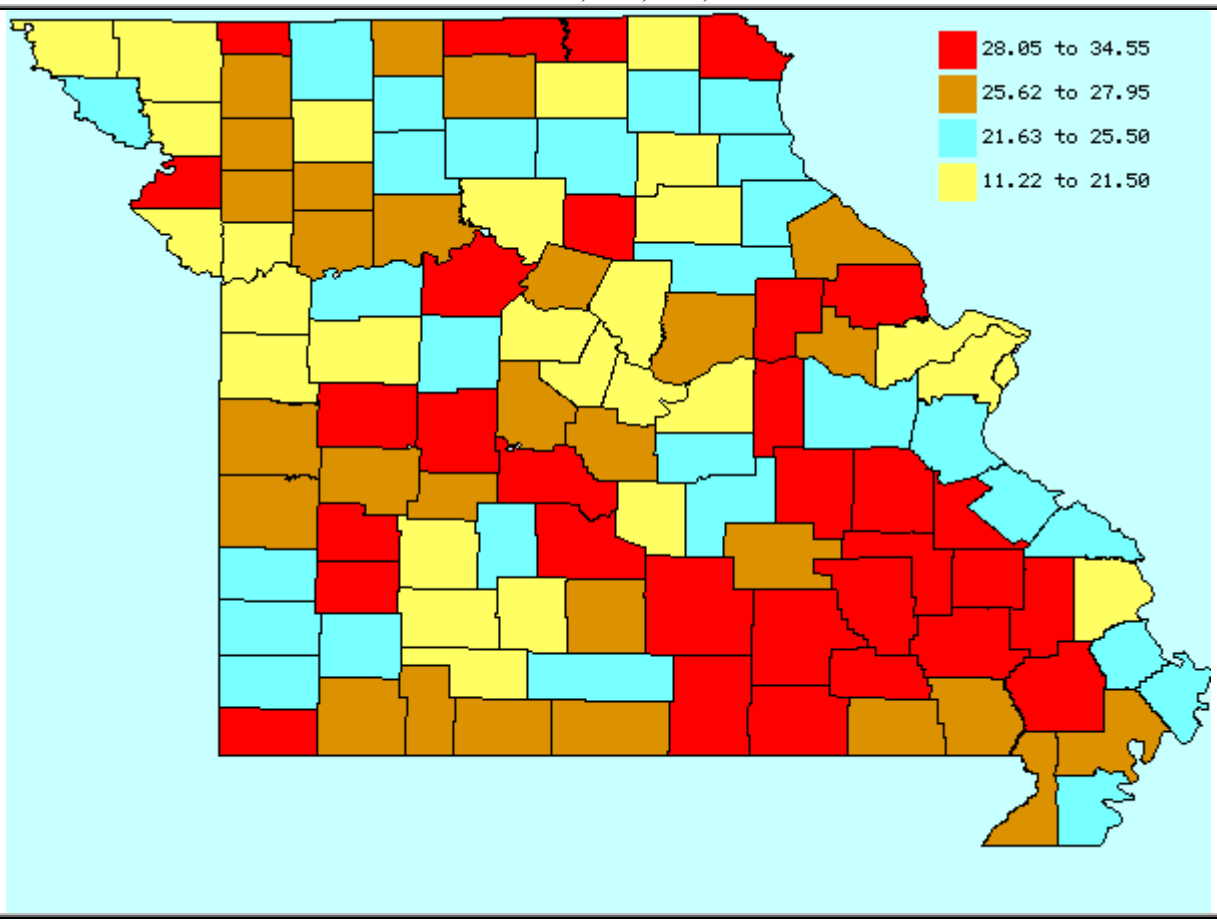
Missouri Births								
Percents – Spacing less than 18 Months								
Age of Mother: (All Ages) Marital Status: (All Mothers) Medicaid Status (All Mothers)								
Year: 1995,1996,1997,1998								
Rate per 100 – denominator - All mothers who have had a live birth								
County	Number	Percent	County	Number	Percent	County	Number	Percent
Camden	70	10.0	Laclede	114	11.7	Ripley	35	9.1
Cape Girardeau	143	8.4	Lafayette	91	10.4	St. Charles	804	8.8
Carroll	36	12.2	Lawrence	144	12.9	St. Clair	31	14.1
Carter	15	8.2	Lewis	29	9.5	St. Francois	163	10.9
Cass	228	9.2	Lincoln	159	12.9	St. Louis County	2722	9.4
Cedar	45	13.5	Linn	50	11.8	St. Louis City	1679	13.3
Chariton	13	6.9	Livingston	51	11.2	Ste. Genevieve	32	7.2
Christian	118	7.8	McDonald	103	12.7	Saline	83	12.9
Clark	23	11.4	Macon	51	10.7	Schuyler	5	4.2
Clay	452	8.6	Madison	33	10.9	Scotland	14	6.9
Clinton	63	11.1	Maries	19	8.4	Scott	149	11.0
Cole	174	8.7	Marion	87	10.0	Shannon	20	9.3
Cooper	42	9.5	Mercer	9	9.7	Shelby	13	7.3
Crawford	91	12.7	Miller	81	11.2	Stoddard	56	8.7
Dade	20	9.5	Mississippi	62	14.2	Stone	77	10.8
Dallas	66	13.7	Moniteau	45	10.1	Sullivan	28	12.5
Daviess	44	15.3	Monroe	28	10.3	Taney	135	13.1
DeKalb	27	10.9	Montgomery	36	11.7	Texas	82	13.3
Dent	40	10.0	Morgan	59	10.9	Vernon	65	10.4
Douglas	46	13.0	New Madrid	92	14.9	Warren	57	8.1
Dunklin	171	16.6	Newton	185	11.3	Washington	69	10.9
Franklin	290	9.6	Nodaway	32	6.8	Wayne	18	6.1
Gasconade	41	10.6	Oregon	26	8.7	Webster	186	16.7
Gentry	27	14.4	Osage	30	7.2	Worth	4	7.4
State of Missouri	17700	10.6				Wright	94	15.4

Missouri Births

Percents – Smoking during Pregnancy

Age of Mother: (All Ages) Marital Status: (All Mothers) Medicaid Status (All Mothers)

Year: 1995,1996,1997,1998



Rate per 100 – denominator - All Births

County	Number	Percent	County	Number	Percent	County	Number	Percent
Adair	214	19.2	Greene	2388	19.4	Ozark	106	25.8
Andrew	146	21.4	Grundy	130	25.1	Pemiscot	327	21.6
Atchison	50	19.7	Harrison	88	23.3	Perry	207	22.6
Audrain	322	25.4	Henry	312	31.9	Pettis	509	24.3
Barry	482	26.0	Hickory	85	27.8	Phelps	398	22.4
Barton	174	24.2	Holt	48	24.0	Pike	204	25.9
Bates	226	27.8	Howard	115	27.0	Platte	562	14.7
Benton	204	32.3	Howell	568	29.7	Polk	227	17.1
Bollinger	153	31.0	Iron	190	34.5	Pulaski	503	20.8
Boone	1063	15.5	Jackson	6849	17.8	Putnam	75	31.9
Buchanan	1261	28.5	Jasper	1350	22.4	Ralls	86	24.2
Butler	579	27.3	Jefferson	2667	24.7	Randolph	389	30.3

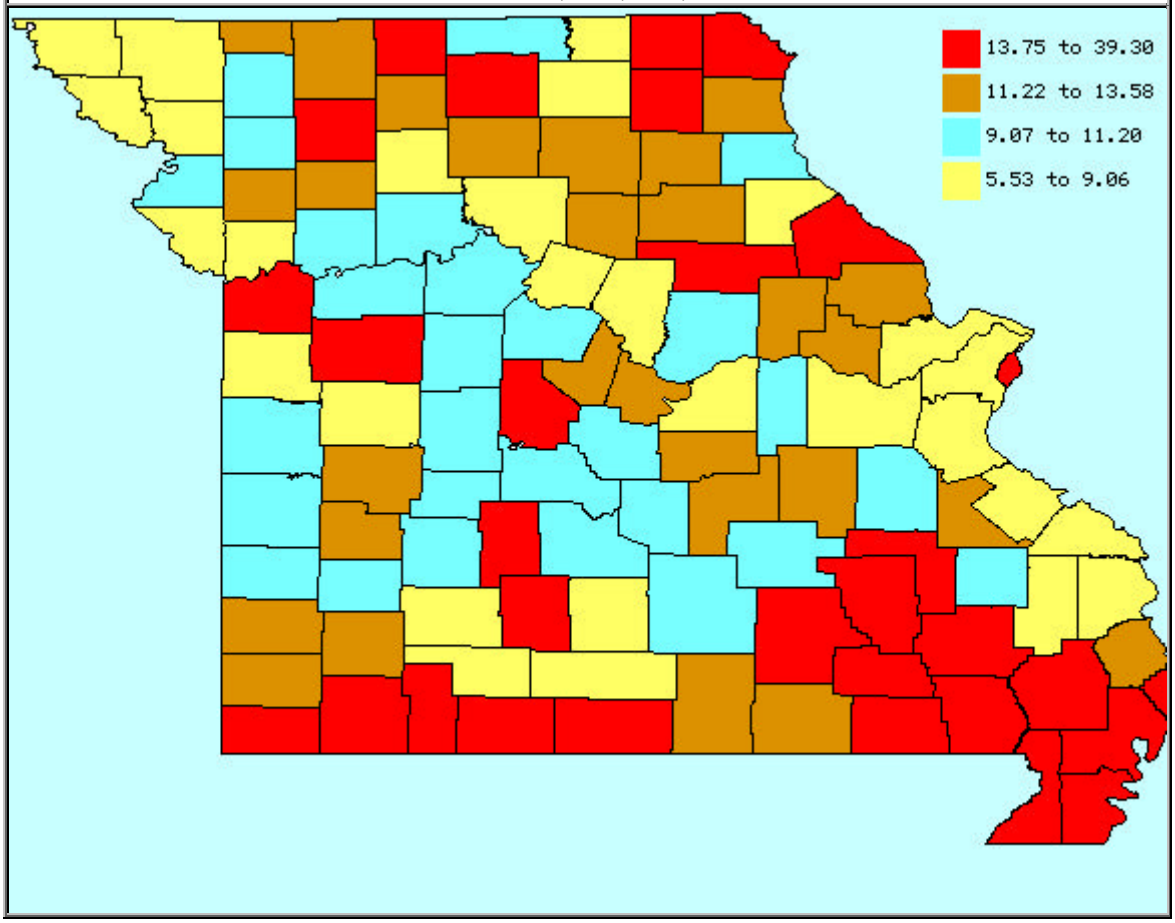
Missouri Births								
Percents - Smoking during Pregnancy								
Age of Mother: (All Ages) Marital Status: (All Mothers) Medicaid Status (All Mothers)								
Year: 1995,1996,1997,1998								
Rate per 100 - denominator - All Births								
County	Number	Percent	County	Number	Percent	County	Number	Percent
Caldwell	104	25.6	Johnson	410	15.9	Ray	313	26.5
Callaway	472	25.9	Knox	47	23.1	Reynolds	85	29.1
Camden	366	28.4	Laclede	476	28.0	Ripley	181	26.4
Cape Girardeau	562	17.9	Lafayette	341	22.8	St. Charles	2540	16.2
Carroll	130	26.3	Lawrence	423	22.7	St. Clair	103	26.8
Carter	95	28.2	Lewis	120	22.6	St. Francois	793	30.1
Cass	891	20.6	Lincoln	590	30.5	St. Louis County	5857	11.2
Cedar	187	31.9	Linn	178	25.5	St. Louis City	4021	17.4
Chariton	65	21.2	Livingston	170	23.9	Ste. Genevieve	164	22.3
Christian	413	15.4	McDonald	411	31.2	Saline	348	30.6
Clark	96	29.3	Macon	173	21.7	Schuyler	61	29.3
Clay	1749	18.0	Madison	167	29.7	Scotland	52	17.9
Clinton	251	26.3	Maries	96	25.1	Scott	553	23.6
Cole	593	16.6	Marion	398	25.3	Shannon	110	28.6
Cooper	152	19.6	Mercer	45	28.0	Shelby	63	20.4
Crawford	394	32.4	Miller	342	27.9	Stoddard	372	29.2
Dade	106	29.6	Mississippi	186	23.1	Stone	343	27.4
Dallas	179	22.4	Moniteau	145	19.5	Sullivan	98	26.7
Daviess	94	20.7	Monroe	92	21.5	Taney	502	25.6
DeKalb	103	26.2	Montgomery	156	29.2	Texas	310	28.9
Dent	184	26.2	Morgan	236	27.0	Vernon	294	27.6
Douglas	133	22.5	New Madrid	288	26.2	Warren	330	27.2
Dunklin	501	26.6	Newton	640	22.9	Washington	356	30.0
Franklin	1207	23.8	Nodaway	127	14.7	Wayne	181	31.3
Gasconade	200	29.9	Oregon	134	28.1	Webster	325	18.4
Gentry	86	27.1	Osage	97	14.7	Worth	32	32.7
State of Missouri	57704	19.5				Wright	258	26.1

Missouri Births

Percents - Inadequate Prenatal Care

Age of Mother: (All Ages) Marital Status: (All Mothers) Medicaid Status (All Mothers)

Year: 1995,1996,1997,1998



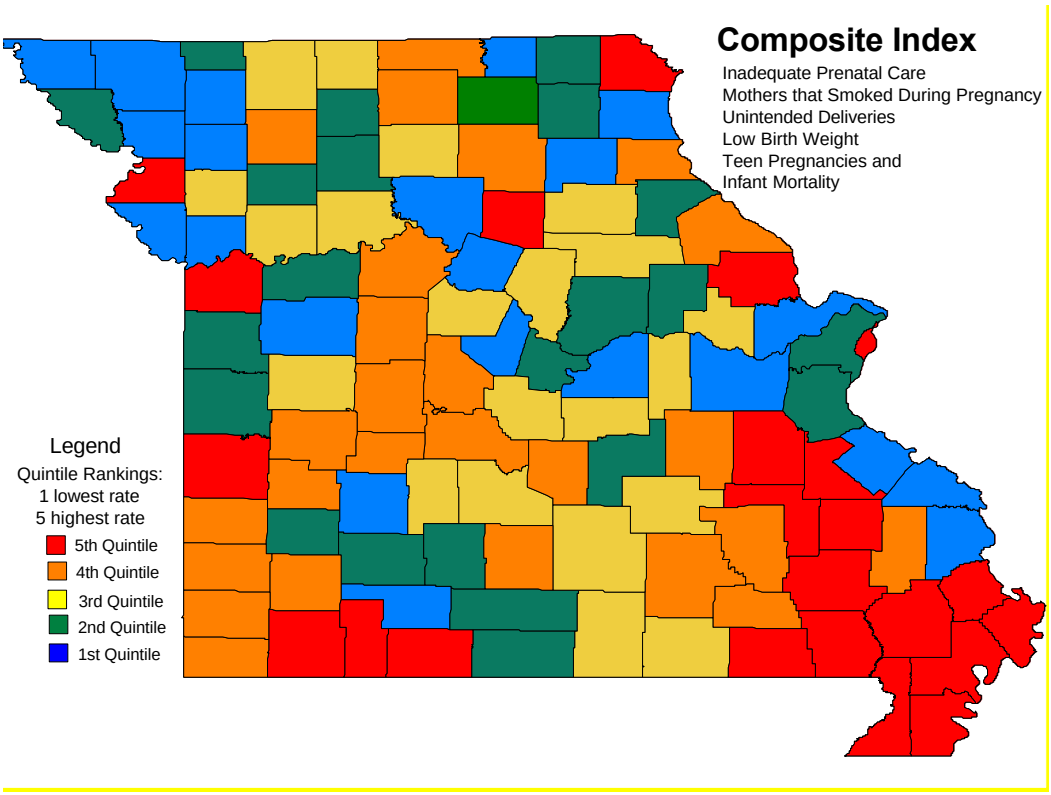
Rate per 100 - denominator - All mothers for whom adequacy of care is known

County	Number	Percent	County	Number	Percent	County	Number	Percent
Adair	95	8.6	Greene	1067	8.7	Ozark	62	15.1
Andrew	42	6.2	Grundy	65	12.6	Pemiscot	425	29.6
Atchison	14	5.5	Harrison	45	12.4	Perry	53	5.8
Audrain	200	16.1	Henry	78	8.2	Pettis	212	10.3
Barry	265	14.3	Hickory	32	10.5	Phelps	207	11.7
Barton	78	10.9	Holt	16	8.0	Pike	117	15.0
Bates	81	10.3	Howard	35	8.6	Platte	262	7.1
Benton	64	10.4	Howell	214	11.2	Polk	130	9.8
Bollinger	33	6.8	Iron	87	16.0	Pulaski	258	10.8
Boone	598	9.1	Jackson	4963	13.8	Putnam	23	9.9
Buchanan	483	11.0	Jasper	801	13.4	Ralls	30	8.6
Butler	422	21.9	Jefferson	787	7.4	Randolph	140	11.7
Caldwell	47	11.9	Johnson	361	14.4	Ray	126	11.2

Missouri Births								
Percents - Inadequate Prenatal Care								
Age of Mother: (All Ages) Marital Status: (All Mothers) Medicaid Status (All Mothers)								
Year: 1995,1996,1997,1998								
Rate per 100 - denominator - All mothers for whom adequacy of care is known								
County	Number	Percent	County	Number	Percent	County	Number	Percent
Callaway	170	9.5	Knox	37	18.4	Reynolds	64	22.8
Camden	120	9.7	Laclede	158	9.4	Ripley	168	26.7
Cape Girardeau	196	6.2	Lafayette	142	9.7	St. Charles	1052	6.8
Carroll	48	9.8	Lawrence	223	12.0	St. Clair	52	13.6
Carter	68	21.9	Lewis	63	12.0	St. Francois	310	11.8
Cass	330	8.1	Lincoln	238	12.4	St. Louis County	4225	8.3
Cedar	70	12.0	Linn	85	12.4	St. Louis City	5220	23.7
Chariton	21	7.3	Livingston	42	6.0	Ste. Genevieve	65	8.9
Christian	155	5.8	McDonald	189	14.6	Saline	116	10.4
Clark	48	15.2	Macon	91	11.7	Schuyler	13	6.3
Clay	701	7.5	Madison	61	11.0	Scotland	112	39.3
Clinton	109	11.7	Maries	46	12.5	Scott	293	12.8
Cole	402	11.6	Marion	163	10.4	Shannon	55	14.6
Cooper	83	11.2	Mercer	22	13.8	Shelby	37	12.2
Crawford	137	11.3	Miller	128	10.9	Stoddard	229	19.0
Dade	34	9.5	Mississippi	149	19.0	Stone	183	14.8
Dallas	110	14.0	Moniteau	91	12.7	Sullivan	61	16.8
Daviess	110	24.3	Monroe	53	13.0	Taney	278	14.4
DeKalb	35	9.1	Montgomery	59	11.4	Texas	115	10.8
Dent	69	9.9	Morgan	138	16.5	Vernon	100	9.5
Douglas	41	7.0	New Madrid	236	22.6	Warren	144	12.1
Dunklin	463	25.8	Newton	375	13.5	Washington	130	11.0
Franklin	384	7.7	Nodaway	62	7.2	Wayne	142	26.1
Gasconade	72	10.9	Oregon	60	12.7	Webster	375	21.3
Gentry	29	9.2	Osage	57	8.9	Worth	11	11.3
State of Missouri	33629	11.7				Wright	86	8.8

Missouri Pregnancy Statistics for The State of Missouri										
	Years									
Age of Mother	1995		1996		1997		1998		1995,1996,1997,1998	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Under 18	5,178	6.0	5,035	5.7	4,835	5.5	4,619	5.2	19,667	5.6
18-19	8,263	9.5	8,255	9.4	8,141	9.3	8,350	9.4	33,009	9.4
20-24	23,973	27.6	24,067	27.3	23,760	27.1	24,429	27.6	96,229	27.4
25-34	40,746	46.9	41,535	47.1	41,494	47.3	41,293	46.7	165,068	47.0
35 plus	8,680	10.0	9,224	10.5	9,445	10.8	9,732	11.0	37,081	10.6
All Ages	86,873	100.0	88,162	100.0	87,707	100.0	88,443	100.0	351,185	100.0
Footnote	* indicates no or insufficient data									

To better determine where geographical need is the greatest throughout Missouri, a composite analysis of six indicators related to national MCH performance measures and health status indicators was completed. A composite analysis of adequate prenatal care, frequency of teenage pregnancies, infant mortality rates, unintended pregnancies, mothers that smoked during pregnancy, and low birth weight was completed. This analysis resulted in the identification of quintiles of highest and high priority for better focusing Missouri's resources to meet MCH priority needs and to better achieve MCH outcomes. The following composite map and table outline this analysis:



Missouri 2001 Maternal and Child Health Composite Health Status Index

Inadequate Prenatal Care (IPNC), Mothers that Smoke During Pregnancy (MSDP), Unintended Deliveries, Low Birth Weight (LBW) and Teen Pregnancies

	Quintile Rankings						
County	***IPNC***	***MSDP***	***Unintended***	***Infant Death***	***LBW***	***Teen Preg***	***Composite***
Adair	1	2	2	4	3	2	14
Andrew	1	1	3	5	1	1	12
Atchison	1	1	4	1	1	1	9
Audrain	5	2	2	4	1	3	17
Barry	4	4	4	4	4	4	24
Barton	3	4	3	2	3	5	20
Bates	2	3	1	5	1	4	16
Benton	4	5	5	3	2	3	22
Bollinger	1	5	3	4	4	3	20
Boone	2	1	2	3	5	4	17
Buchanan	3	4	5	3	4	5	24
Butler	5	4	5	5	5	5	29
Caldwell	4	2	2	1	3	2	14

	Quintile Rankings						
County	**IPNC**	**MSDP**	**Unintended**	**Infant Death**	**LBW**	**Teen Preg**	**Composite**
Callaway	1	3	3	2	4	3	16
Camden	3	4	4	5	4	3	23
Cape Girardeau	1	1	2	2	2	2	10
Carroll	1	3	4	4	3	2	17
Carter	5	3	3	2	4	5	22
Cass	2	2	2	2	3	2	13
Cedar	4	5	3	5	1	3	21
Chariton	1	3	4	1	2	1	12
Christian	1	1	1	2	2	2	9
Clark	5	5	4	5	5	1	25
Clay	1	1	1	2	2	2	9
Clinton	2	3	2	4	3	3	17
Cole	3	1	1	4	3	2	14
Cooper	3	1	2	5	5	1	17
Crawford	3	5	3	2	4	4	21
Dade	1	3	1	4	3	1	13
Dallas	3	1	1	5	4	3	17
Daviess	5	4	4	5	1	3	22
De Kalb	2	4	2	1	2	1	12
Dent	2	4	3	1	5	4	19
Douglas	1	2	1	4	4	3	15
Dunklin	5	3	5	4	5	5	27
Franklin	2	2	3	1	2	2	12
Gasconade	3	5	4	2	1	3	18
Gentry	1	4	1	1	1	4	12
Greene	2	1	3	3	3	3	15
Grundy	2	4	3	3	1	3	16
Harrison	4	2	4	2	2	3	17
Henry	1	4	3	4	2	4	18
Hickory	2	2	4	5	5	5	23
Holt	2	2	3	3	1	2	13
Howard	1	3	1	1	3	1	10
Howell	2	4	2	3	4	4	19
Iron	5	5	5	1	5	3	24
Jackson	4	1	5	4	5	5	24
Jasper	3	2	4	2	4	5	20
Jefferson	1	3	3	1	3	2	13
Johnson	4	1	1	2	1	2	11
Knox	5	2	2	1	2	1	13
Laclede	2	3	4	3	3	4	19

	Quintile Rankings						
County	**IPNC**	**MSDP**	**Unintended**	**Infant Death**	**LBW**	**Teen Preg**	**Composite**
Lafayette	2	2	3	3	4	2	16
Lawrence	3	3	3	2	5	4	20
Lewis	3	3	2	1	1	1	11
Lincoln	3	5	5	4	4	3	24
Linn	4	3	2	3	2	5	19
Livingston	1	1	4	1	1	5	13
McDonald	4	5	5	1	3	5	23
Macon	4	2	5	5	4	3	23
Madison	3	5	5	5	2	5	25
Maries	4	3	2	4	3	1	17
Marion	3	4	4	5	3	4	23
Mercer	4	2	1	5	4	3	19
Miller	3	4	3	2	3	4	19
Mississippi	5	3	5	4	5	5	27
Moniteau	4	1	1	1	3	2	12
Monroe	4	2	1	5	3	2	17
Montgomery	3	3	2	1	2	2	13
Morgan	5	3	3	2	3	4	20
New Madrid	5	3	5	5	5	5	28
Newton	4	2	4	3	5	3	21
Nodaway	1	1	1	4	1	1	9
Oregon	3	5	4	2	2	1	17
Osage	3	1	1	2	1	1	9
Ozark	5	4	1	1	2	1	14
Pemiscot	5	2	5	5	5	5	27
Perry	1	2	2	1	1	2	9
Pettis	3	3	4	3	5	4	22
Phelps	4	2	2	3	2	3	16
Pike	3	4	4	5	3	2	21
Platte	1	1	1	2	2	1	8
Polk	2	1	1	2	1	1	8
Pulaski	2	2	2	4	5	5	20
Putnam	4	5	4	3	2	2	20
Ralls	4	5	2	1	1	1	14
Randolph	3	4	5	4	5	4	25
Ray	3	3	3	2	3	3	17
Reynolds	5	5	4	3	3	3	23
Ripley	5	5	5	5	5	4	29
St. Charles	1	1	1	1	1	1	6
St. Clair	4	5	4	2	2	5	22

	Quintile Rankings						
County	***IPNC***	***MSDP***	***Unintended***	***Infant Death***	***LBW***	***Teen Preg***	***Composite***
St. Francois	4	5	5	3	4	3	24
St. Louis Co	2	1	2	3	4	2	14
Ste. Genevieve	1	3	3	4	2	1	14
Saline	2	3	5	4	4	5	23
Schuyler	1	5	1	1	1	1	10
Scotland	5	1	2	1	2	2	13
Scott	3	2	5	5	5	4	24
Shannon	5	4	1	3	5	4	22
Shelby	4	1	2	1	1	1	10
Stoddard	5	5	5	3	4	4	26
Stone	5	5	5	2	4	4	25
Sullivan	5	4	3	3	5	1	21
Taney	4	4	4	4	4	5	25
Texas	2	4	3	3	2	5	19
Vernon	2	5	3	5	5	5	25
Warren	2	5	2	4	2	2	17
Washington	2	5	5	5	3	4	24
Wayne	5	4	5	5	5	4	28
Webster	5	2	1	3	1	2	14
Worth	4	2	1	2	1	4	14
Wright	2	3	4	3	4	5	21
St. Louis City	5	1	5	5	5	5	26

Missouri's Title V MCH planning and assessment activities do not occur in an institutional vacuum. In 1998 and 1999, the Division of Maternal, Child and Family Health provided primary staff support for Governor Carnahan's Healthy Missourians Sub-Cabinet. This initiative called for the formation of an interagency team that assessed the impact of state supported interventions upon increasing the number of healthy babies; decreasing infant mortality; and reducing unintended teenage pregnancies in Missouri. Approaches with a primary impact upon these MCH related "Show Me Results" areas were delineated:

Approaches & Programs With Primary Impact
FFY99 Budget Resources

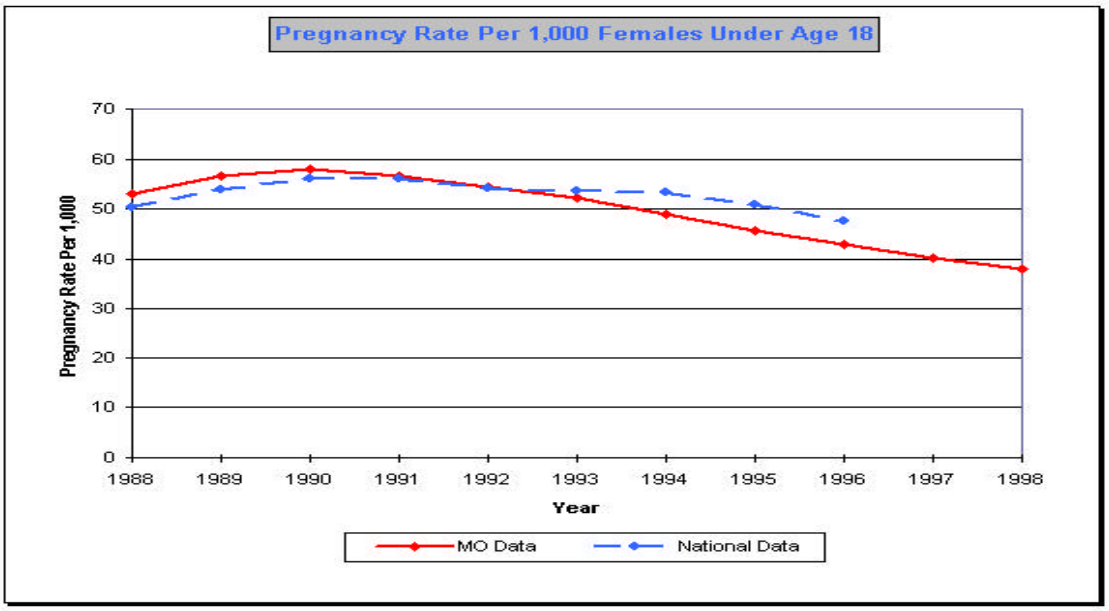
1.	**Family Planning**		$ 8,556,897
•	*DSS Family Planning Program*	$1,995,862	
•	*DOH Family Planning Program*	6,561,035	
2.	**Prenatal Care**		$12,424,613
•	*DSS Physician Advanced Practice Nurse Program*	$6,332,115	
•	*DSS Medicaid Case Management of Pregnant Women*	284,298	
•	*DSS Nurse Midwife Program*	141,607	
•	*DSS Presumptive Eligibility: Prenatal Care*	1,611,723	
•	*DSS Outreach Services for Pregnant Women*	986,149	
•	*DOH Prenatal Care Coordination*	68,721	
3.	**Substance Abuse Initiatives**		$ 7,759,422
•	*DMH Women and Children's Treatment Program*	$7,651,933	
•	*DOH Perinatal Substance Abuse Program*	107,489	
4.	**Community Prevention & Referral**		$12,319,927
•	DMH Tobacco Sales Compliance Inspections	$ 396,450	
•	DMH Prevention of Drug and Tobacco Use in ***Pregnant Teens and Adults***	6,870,542	
•	*DOH ASSIST Program (Smoking Prevention)*	$1,107,149	
•	*DSS/DOH EPSDT Program*	661,886	
•	*DOH Abstinence Education*	1,193,539	
•	*DOH Adolescent Health Initiatives*	352,664	
•	*DOH Alternatives to Abortion*	1,199,041	
•	*DOH SIDS Prevention Program*	52,656	
•	*DOH Breastfeeding Promotion Program*	486,000	
5.	**Nutrition Education & Food Supplements**		$ 591,804
•	*DOH PKU Formula Program*	$ 163,543	
•	*DOH (WIC) Folic Acid and Other Supplements*	428,261 (estimate)	
Grant Total of Programs with Primary Impact			**$41,652,663**

KEY TO STATE AGENCIES SUPPORTING APPROACHES AND PROGRAMS WITH PRIMARY IMPACT UPON SMRS UNDER STUDY:

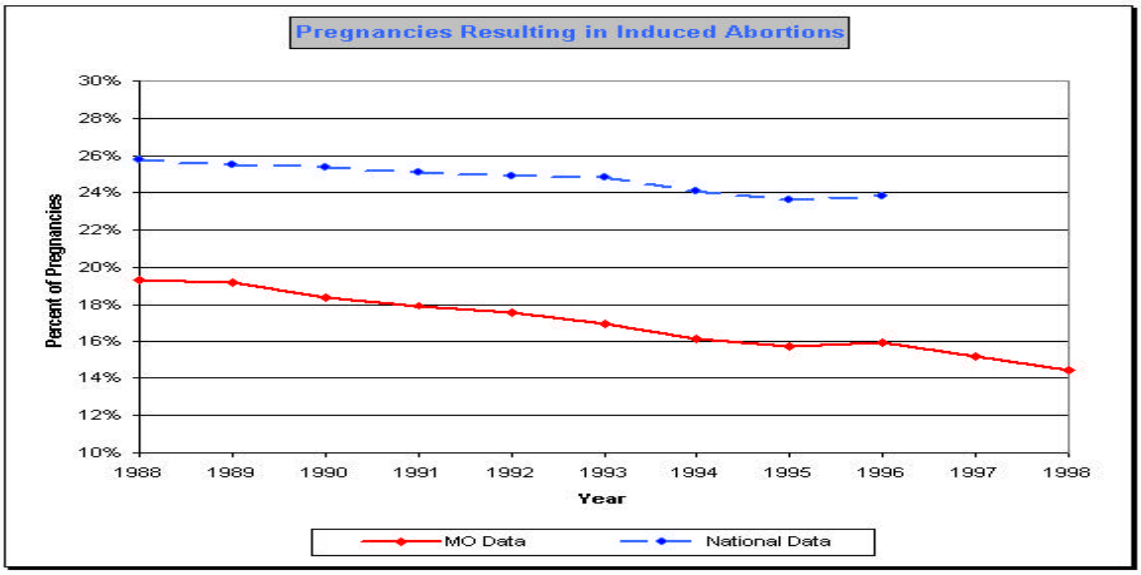
DSS = DEPARTMENT OF SOCIAL SERVICES
DOH = DEPARTMENT OF HEALTH
DMH = DEPARTMENT OF MENTAL HEALTH

Based on this interagency assessment, the following conclusions were forwarded to Governor Carnahan's Office:

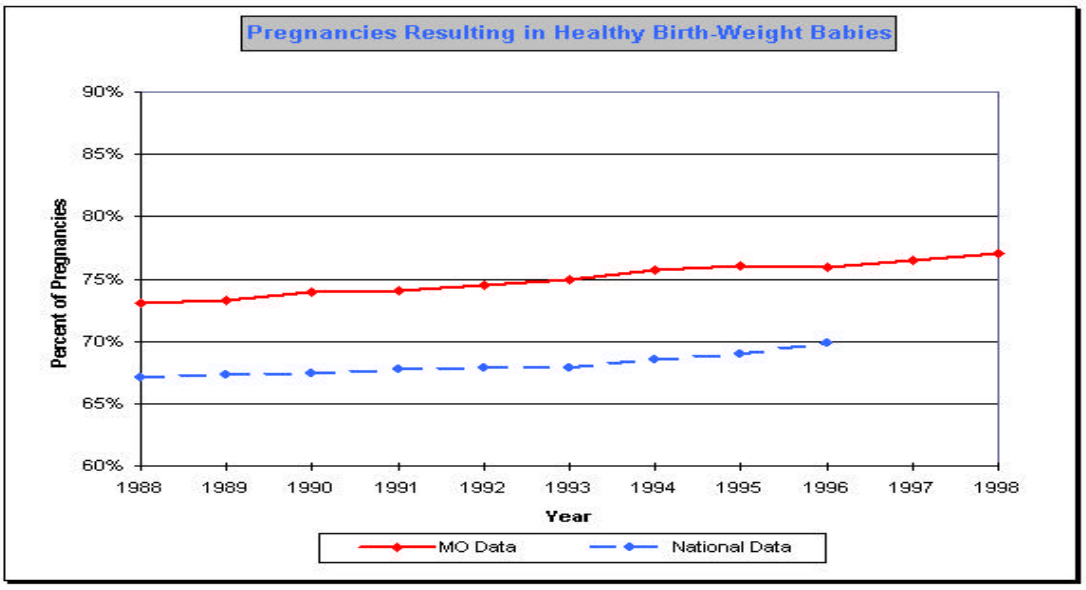
- Missouri continues to make significant progress in reducing pregnancies among teenagers. The rate steadily declined forma high of 58 per 1000 in 1990 to 38 per 1000 in 1998.



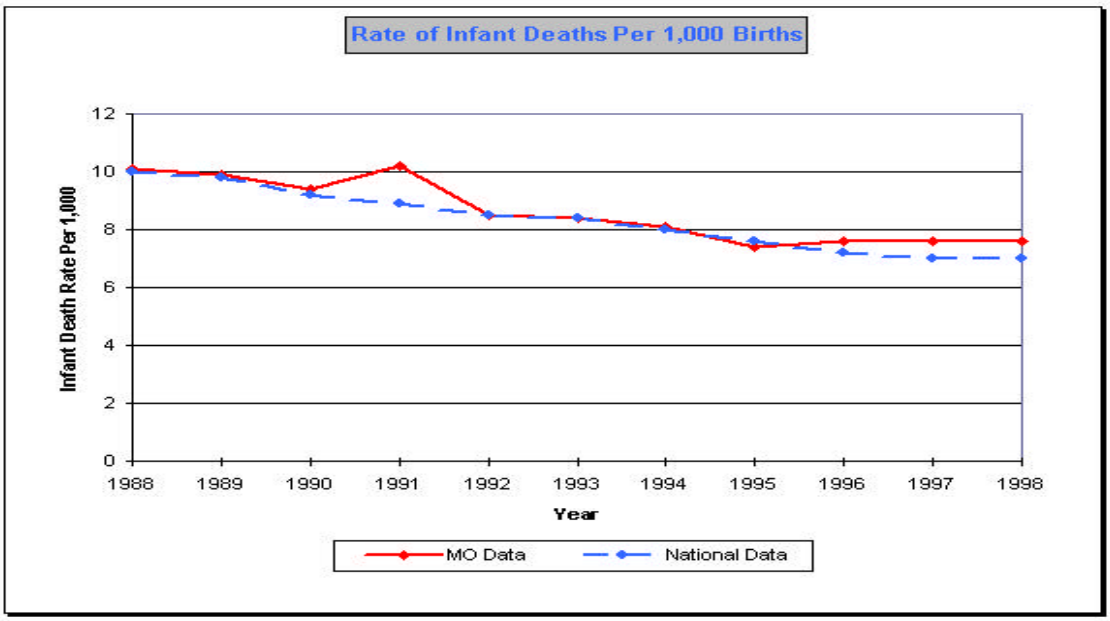
- Missouri has also achieved significant reductions in the percent of pregnancies resulting in induced abortion. The rate has declined from 19.3 percent in 1988 to 14.4 percent in 1998.



- The percent of pregnancies that result in healthy birth weight babies that steadily increased over the past ten years – but has remained relatively flat since 1995.



- After achieving decreases in the rate of infant mortality for several years, there has been no significant change since 1995.
- There is a significant disparity between the white infant mortality rate and the black infant mortality rate. In 1998, the infant mortality rate for whites was 6.1 per 1000 births while the rate for blacks was 16.7 per 1000 births



The Title V MCH needs assessment process and the Healthy Missourians Sub-Cabinet assessment process have helped demonstrate that no single "magic bullet" solution can be applied in Missouri to dramatically improve MCH outcomes in a short time frame. Progress is more likely to be achieved incrementally. Continued support of family planning to reduce unintended pregnancies, becomes the cornerstone of any statewide strategy to further reduce infant mortality, teenage pregnancy, and low birth weight babies. Accessible prenatal services for women of childbearing age, continue to be another crucial intervention in any statewide strategy to achieve desirable outcomes associated with Title V MCH outcomes and performance measures. Programs including folic acid supplement usage and promotion of breastfeeding to raise infection fighting antibody levels in infants and reduce the incidence of SIDS, are part of continuous nutritional education and food supplement usage before, during and after pregnancy. Finally, as this assessment would indicate, greater support of proven MCH interventions should begin to be better focused in areas of greatest geographical need throughout Missouri.

3.2.1 Priority Needs

Direct & Enabling Services

- *Healthcare Access:* Despite successful efforts to enroll children in the State Children's Health Insurance Program, many children in this state have little or no access to primary dental care. Since 1980, there has been a dramatic increase in the number of children diagnosed with asthma in Missouri. Many of the 87,600 asthmatic children in Missouri do not have adequate access to the primary and specialized services they require. Eighteen to twenty percent of all children in Missouri have a chronic physical or mental condition requiring services that typically extend beyond those needed by healthy children. Many of these children with special health care needs still do not have adequate access to the primary and specialized services they require.
  - ϑ *Lack of **access to dental health** services required by children*
  - ϑ *Lack of **"Medical Home**" for children with special health care needs*
  - ϑ *Lack of basic **health insurance coverage** for over 50,000 children*

  Related Health Status Indicator(s): (C1), (C2), (C3), (C6), (D4)

Population Based Services

- *Prevention of Smoking Among Children and Adolescents:* Missouri had the second highest teen smoking rate in the nation in 1995 and the fifth highest in 1997.Overall there has been a 60 percent increase in tobacco use among Missouri high school seniors since 1991 and the gap between the state and the national rate continues to widen. Almost 90 percent of adults in Missouri who have become regular smokers began smoking at or before age 18.
- *Unintended Pregnancies:* A major factor impacting low birth weight babies and entrance into first trimester care, is the intent to conceive, as women with unintended pregnancies are less likely to receive early prenatal care, needed nutritional supplements including folic acid and are likely to use alcohol, tobacco or other substances. There is also a strong correlation between unintended pregnancies, low income levels and Medicaid women. In 1998, over 60% of all unintended births were among low income Medicaid women.

  Related Health Status Indicator(s): (C4), (C7), (C8)
- *Child and Adolescent Injuries:* Missouri continues to exceed the U.S. average in three of the five leading causes of premature death among MCH populations: motor vehicle-related fatalities; suicides; and deaths caused by firearms. In 1998, the 15-19 year old age group had the highest rate of death due to motor vehicle accidents in Missouri.

  Related Health Status Indicator(s): (D1), (D2)
- *Child Abuse & Neglect:* In 1998, there were more than 48,119 reports of child abuse and neglect to the Division of Family Services Hotline, involving more than 75,000 children. From these reports, 12,556 children were confirmed as abused or neglected. Physical neglect (54.6% of children) was found much more frequently in child abuse investigations than physical abuse (21.7%). Sexual abuse was found in 18.3% of confirmed cases. More than one-third of the children in cases of probable cause were less than six years old. Almost three quarters of children (31) who died as a result of child abuse or neglect were less than six years old.
- *Minority Health Disparities: Infant Mortality and Other MCH Indicators:* There are readily apparent disparities between African-Americans and all other race/ethnic groups for virtually every MCH indicator. The overall infant death

rate among African-Americans exceeds that of any other group. The African-American neonatal death rate is 2.3 times the rate for all other births combined in Missouri. Pre-term birth is most prevalent among African-Americans, while the African-American LBW rate is about double the rate for other groups.

Related Health Status Indicator(s): (D6a), (D6b), (D7a), (D7b), (D8a), (D8b), (D9a), (D9b), (D10), (D11), (D12)

Infrastructure Services

- *Expanded MCH Information Systems:* The collection, management and dissemination of data on MCH health status, outcomes, process and structure is key to developing an effective and accountable delivery system serving MCH populations in Missouri. Customized data systems are required to track national and state MCH performance measures. MCH health status indicators need to be integrated within data systems already supported by the Center for Health Information and Management Epidemiology. Expanding partnerships with managed care plans to track and analyze best practice MCH indicators, is another crucial element of Missouri's evolving MCH electronic information system. Finally, the capability of local communities and regions to electronically patch into this evolving MCH information system, needs to be further enhanced.

  Related Health Status Indicators: (C5)

See also Table 1 and 2 in the Other Supporting Documents Section 5.3

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

Please refer to the All Other Forms Section 5.8 for the required budget forms 2,3,4 and 5. Estimates have been used in providing budget details. In the case of "types of individuals served," the budget is based upon a percentage breakdown by program and service area as to which types of individuals are impacted by the services provided. Form 5, State Title V Programs Budget and Expenditures by Types of Service, parallels the pyramid shown in Figure 3 which organizes maternal and child

health services hierarchically from direct health care services through infrastructure building.

Form 2 shows an unobligated balance of $1,500,000, the expected carryover from FFY2000. Missouri is using over half of this projected carryover amount to support the implementation of evidence-based tobacco use prevention programs targeting adolescents. The DMCFH will collaborate with the Division of Chronic Disease Prevention and Health Promotion to implement a media campaign designed to prevent adolescents from starting to smoke and to encourage other adolescents to stop smoking. Efforts are underway to utilize the additional carryover in a manner that supports measure to achieve both national and state performance measures.

3.3.2 Other Requirements

Maintenance of Effort

Missouri is in compliance with the maintenance of effort requirements described in Section 505(a)(4). Missouri has maintained and exceeded efforts of the 1989 program year.

Justification

Every effort is made to match funding to the level of unmet need and to address the four layers of the MCH pyramid and the three target populations. The program budgets take into account the "30-30-10" requirements of Title V. In addition, Missouri uses a fair method to allocate Title V funds among individuals and areas identified as having unmet needs for maternal and child health services. The State uses its MCH funds for the purposes outlined in Title V, Section 505 of the Social Security Act.

The distribution of the funding among the four levels of the pyramid has changed from the previous year. The FFY 2001 budget for direct health care services compared to the FFY 2000 budget shows another decrease of over seven percent. The enabling services budget increased by nearly fifty percent for the same period while the population based budget increased by approximately three percent. Infrastructure support increased by three percent, as well.

The funding composition among the four levels of the pyramid has remained fairly stable from the previous year except for enabling services. The Medicaid income derived from services provided for the Medicaid population is found in enabling services and this has contributed significantly to the increase in this type of service.

Missouri continues to re-examine its programs and services and their relationship to core public health activities and makes changes based upon the need of the population. For example, the total amount budgeted for children with special health care needs increased about $1,750,000, however, the partnership budget for payments for direct care for children with special health care needs is being reduced by another $500,000. State general revenue, as was the case in FY2000, is now used for all direct care payments for the CSHCN program. The influence of the State Children's Health Insurance Program (SCHIP) continues to have a strong impact upon this direct health care service. It is anticipated that declines in health care payments for SHCN will persist as more of the population receives coverage for the SCHIP program. Funding is being diverted from direct care payments to establish other services; these include outreach, education, and training of providers and caregivers for the special needs population. Since FFY96, the federal-state budget for direct health care services has declined over $6.5 million, from 52.9 percent of the total budget in FFY 1996 to 24.2 percent in FFY2001.

Population based services commands 35.3 percent of the budget in FFY2001 compared to 18.1 percent in FFY96. The FFY2001 budget for population based services is comparatively stable to last year's budgeted amount.

Infrastructure building services is also fairly stable compared to last year's budget. The slight increase in this type of service is the result of another increase in the state pay plan, and resulting fringe benefits, in both federal and state supported personnel.

Any amount payable to the state under this title from allotments for this fiscal year which remain unobligated at the end of that year are carried forward and obligated in the following fiscal year. The Department and the Office of Administration maintain budget documentation for Block Grant funding and expenditures consistent with Section 505(a) and Section 506(a)(1) for the purpose of maintaining an audit trail. The grant expenditures are recorded through standard documents in the Statewide Accounting System for Missouri (SAM II). Reporting requirements and procedures for the MCH grant are instituted to comply with conditions specified within the Block Grant guidance.

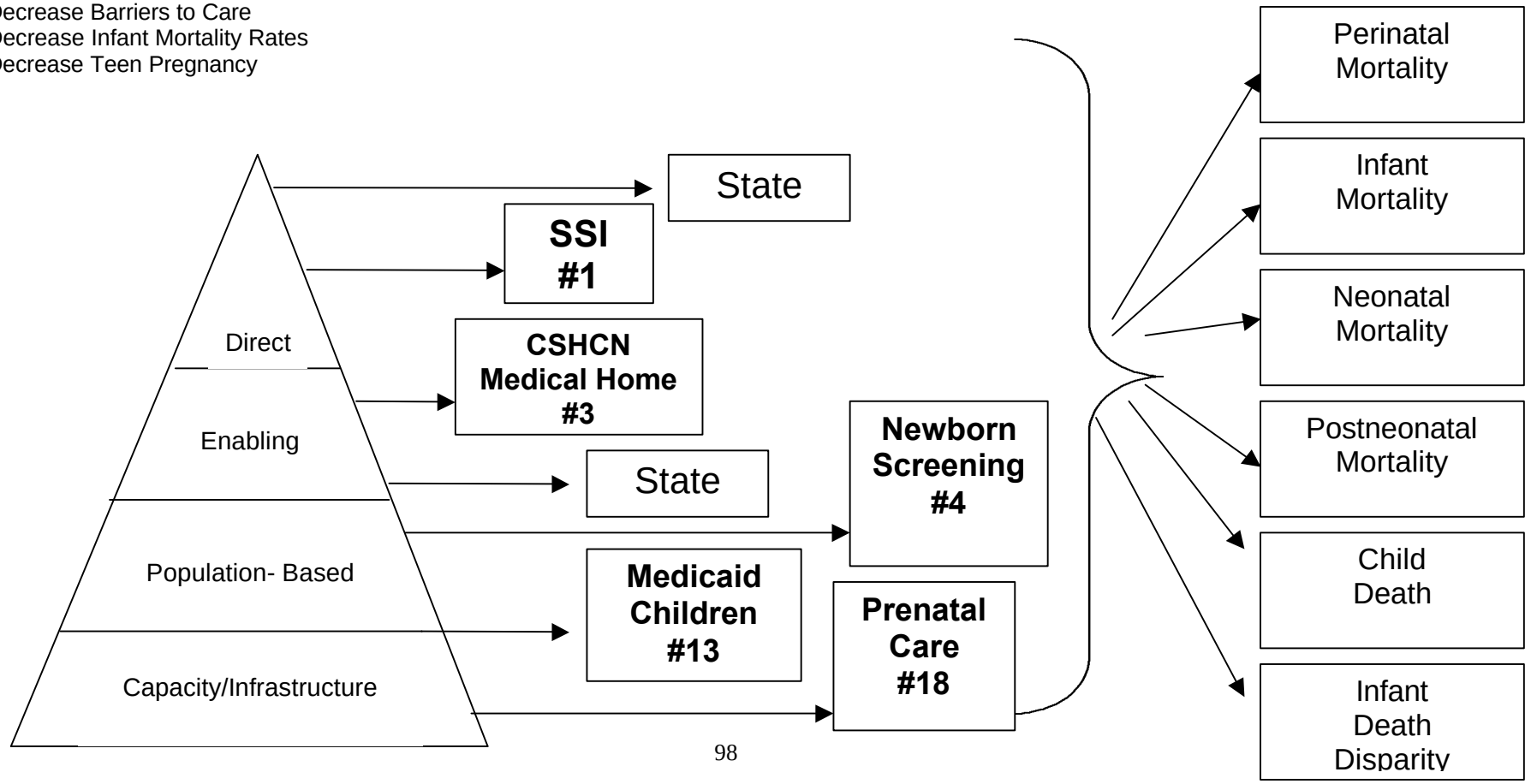
Figure 4

Title V Block Grant
Performance Measurement System

Performance Measures

Priorities (Needs Assessment)

1. Decrease Barriers to Care
2. Decrease Infant Mortality Rates
3. Decrease Teen Pregnancy
4.
5.



3.4 Performance Measures

Figure 4 presents a schematic overview of the entire Title V Block Grant Measurement System. This approach begins with the identification of priorities and culminates in improved outcomes for the Title V population. Accountability is determined in 3 ways: (1) budget and expenditures for the four levels of service represented in the pyramid; (2) by measures of progress towards successful achievement of each individual performance measure; and (3) a positive impact on the outcome measures, if the program interventions and activities are successful.

Missouri's priority needs were discussed in section 3.2.1. Performance and outcome measures are examined in sections 3.4.1 through section 3.4.3. Figure 5 summarizes Missouri's MCHBG-funded services on the MCH pyramid by levels of service, and can be found in section 5.3 of this application. Figure 6 below, Performance Measures Summary Sheet, lists the 18 national and 7 negotiated state performance measures, identifying the specific pyramid level of service and type of service for each.

3.4.1 National "Core" Five Year Performance Measures

See Form 11 for a report on Missouri's status relative to the 18 national performance measures and our five-year objectives relative to each of these.

3.4.1.1 Five Year Performance Objectives

See Form 11. The National "Core" Performance Measure Detail Sheets for Missouri have been placed in Supporting Document Section 5.9.

3.4.2 State "Negotiated" Five Year Performance Measures

See Form 11 and Section 5.10 State "Negotiated" Performance Measure Detail Sheets in Section V Supporting Documents of this application. Objectives added by the state are preceded with the prefix "SP." Also included in the Detail Sheets are descriptions of the state selected measures that includes their category on the pyramid, the Missouri goal, the measure used, how the measure is defined, the measure's relationship to Healthy People 2010 (if there is one), data sources and data issues, and the significance of the indicator or why this particular indicator was chosen.

3.4.2.1 Development of State Performance Measures

Missouri's "negotiated" performance measures were developed through a process that included Department, Division, program and public input. The process began with an initial list of performance measures proposed by the MCH Block Grant Development Team. This team, consisting of one member from each of the units within the Division of Maternal, Child and Family Health, along with members of Division staff, developed these initial measures from criteria listed in section 1.4 which must be referenced in departmental/division strategic plans. The team also felt that any state performance measures selected should not be already addressed by one or more of the MCH national performance measures.

As the FY2001 application was developed, the team made a decision to replace the FFY99 – FFY 2000 *Percent of Women with Inadequate Prenatal Care* state performance measure with a *Percent of Children who Use Tobacco (14-19)* state performance measure. It was felt that the SP measure relating to prenatal care too closely paralleled one of the national MCH performance measures.

The percent of children under age 2 with a subdural hematoma SP measure, is likely to remain inactive for an indefinite period due to a lack of data reporting and collection systems required to track this measure.

Figure 6

PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
16) Percent of very low birth weight live births.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) Percent of women with inadequate prenatal care.**(ELIMINATED)**		X					X
2) Percent of inadequate birth spacing.		X					X
3) Percent of low-income children who consume nutritionally adequate diets.			X				X
4) Percent of citizens drinking fluoridated water.			X				X
5) Percent of women who have reported smoking during pregnancy.			X				X
6) Percent MC+ Managed Care Organizations (MCOs) utilizing MCH data.				X	X		
7) Percent of children under age 2 with a reported subdural hematoma. **(ELIMINATED)**				X		X	
8) Percent of child care facilities receiving health and safety consultation.				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.2 Discussion of State Performance Measures

Figure 6 depicts the relationship to each level of the MCH pyramid. Reducing *the percent of children who use tobacco* is one of the priority MCH health needs in Missouri and some Title V funds will support related interventions. The *percent of inadequate birth spacing* is directly related to another priority need of reducing the number of unintended pregnancies in Missouri. *The percent of women who have reported smoking during pregnancy* is also related to women with unintended pregnancies who are more likely to use alcohol, tobacco and other substances. *The percent of low-income children ages 1-11 who consume nutritionally adequate diets* is directly related to the priority MCH need of reducing disparities in health status among minority groups in Missouri. *The percent of MC+ managed care organizations (MCOs) utilizing MCH data* is directly related to the need for expanded MCH information systems.

3.4.2.3. Five Year Performance Objectives

Please refer to Form 11 for Missouri's Five Year Performance Targets.

3.4.2.4. Review of State Performance Measures

Review to be conducted by HRSA Bureau of Maternal and Child Health staff.

3.4.3 Outcome Measures

As requested, this material is contained on Form 16.

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505(a)(A)]

4.1 Program Activities Related to Performance Measures

4.1.A. Direct Health Care

1. Pregnant Women, Mothers and Infants

No material included

2. Children

No material included

3. Children with special health care needs

01: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

The Department of Elementary and Secondary Education (DESE) Vocational Rehabilitation Disability Determination Unit (DDU) has had a long standing agreement with the Bureau of Special Health Care Needs to refer children with special health care needs to the Bureau for services. However, inconsistencies were discovered in the referral process used by the Disability Determination Unit (DDU), in some geographic areas of the state numerous referrals are made, whereas other areas make sporadic referrals to the BSHCN. During FFY2001, the BSHCN will strengthen collaboration efforts with the local DDU offices to investigate current referral procedures and to determine and implement improvements needed to assure children are referred to the BSHCN when appropriate. During FFY2001, the BSHCN will base planning and policy development on information gathered from a study of the reasons why families do not respond to contact from the BSHCN after referrals are made. As a new electronic data system is developed, Missouri's Health Strategic Architecture and Information Cooperative (MOHSAIC) system, it will be evaluated for the ability to generate

automated referrals. Development and refining of the referral system is necessary for a more direct matching of client needs and program eligibility requirements. The BSHCN will also conduct training for service coordinators regarding Social Security benefits, including SSI and Social Security Disability Income (SSDI). The BSHCN will continue to coordinate with the DESE's vocational rehabilitation case workers in the collaborative effort of assuring that all age-appropriate children with special needs are screened and referred for appropriate services.

02: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to it clients.

The Bureau of Special Health Care Needs, through cooperative agreements, assists in providing specialized coverage for children with special health care needs. The CSHCN program assures access to care for program participants and provides coordination of services once access to care has been achieved. Assurance of quality is facilitated through trained health care providers and adequate funding of services paid for by the CSHCN program. Increased access to quality health care providers is provided through the BSHCN enrollment/credentialing process. The CSHCN program facilitates or finances nine areas of specialty and subspecialty services listed on Form 11. Planning efforts for FFY 2001 include an organized statewide outreach campaign to reintroduce the services of the CSHCN Program to all areas of the state. This is an effort to identify children and families with special health care needs, who are otherwise unaware of funding for specialty services. This will allow the BSHCN to continue to introduce and evaluate the current health care home for primary and preventative care services as well as directing families into the available specialty services required. System analysis of availability of resources continues to be a need and through survey data in FFY 2001 and FFY 2002, we will better identify the gaps in services and profiles of those not well served by current systems of care. Services for children with special health care needs and their families need to be organized in ways that families can use them easily. Continued system development will improve service and communication links at the community level, with providers, community agencies and local public health agencies. Continued efforts to provide referral and build a network for assuring care of the children with special health care needs will occur by increasing collaboration with

district and local public health offices, managed care plans, health care providers and other state and local government agencies including schools.

The bureau will continue to provide service coordination and facilitate client enrollment into new systems of health care such as MC+ and other Medicaid programs. However, the BSHCN is reviewing its service coordination system and identifying opportunities to more effectively complement this statewide service. Organization of services for participants to assist in ease of access will be key in the review process.

Provider enrollment criteria for enrollment of rural hospitals will be under review in order to increase the enrollment of qualified rural providers, thereby providing greater access to services in the rural areas. Review of possible rural hospital affiliation agreements with larger health care centers is required. Affiliation agreements with tertiary care centers to manage the direct care services for children and adults with genetic disorders is under consideration. Assurance of the availability of services in rural areas continues to be a need. Through recruitment of providers, maintenance of the current credentialing system, targeted provider review and development of automated provider credentialing, the credentialing process will enhance access to more quality providers, thereby assuring timely and appropriate services. In FY 2001, progress toward refining this system is a priority.

FFY 2001 will show continued collaboration and interagency agreement with the DESE for Part C initiatives, including state and local interagency coordinating councils. In addition, facilitating awareness with local school districts regarding outreach and identification of children with special health care needs in conjunction with evaluation of school based health care for children with special needs will occur. This will contribute to the development and improvement of community based systems of care for children with special health care needs. Continuation of cooperative agreements with DESE for Part C, Department of Social Services (DSS) for Medicaid and MC+ will assure screenings occur for the children with special health care needs in Missouri.

4.1.B. Enabling Services

1. Pregnant Women, Mothers and Infants

The Infant Mortality Reduction program will be renamed The Healthy Birth Outcomes program. Seven local public health agencies, located in areas with high disparity infant mortality rates, will implement interventions that target specific, evidence-

based factors modifiable during gestation, (such as substance abuse, smoking cessation, folic acid), and will collaborate within the community to provide culturally competent, appropriate services that support early entry into prenatal care. In addition, the Bureau of Family Health, in cooperation with Medicaid, will continue the Prenatal Case Management Quality Assurance Program throughout the state. The bureau is cooperating with the Division of Social Services to enroll pregnant women in the Temporary Medicaid During Pregnancy (TEMP) program. TEMP offers immediate eligibility to ambulatory obstetrical care including laboratory tests and prescriptions related to the pregnancy. These services can be received while a Medicaid application is pending. This decreases the waiting time for pregnant women to become Medicaid eligible. The bureau is currently identifying and developing strategies to encourage pregnant women to begin early prenatal care. For instance, incentives for prenatal visits, expansion of home visitation, inter/intra-agency collaborations to promote early prenatal care, programs to reduce the impediments to reimbursement for prenatal care, and professional and public educational programming are all being considered.

In FFY2000 the Home Visiting programs were expanded to include two new sites based on the David Olds' model of Home Visiting. It is projected that there could be further expansion of this program to offer the program statewide in regional sites. The Bureau of Family Health (BFH) will be collaborating with the Division of Family Services (DFS) to transfer two million dollars from DFS to BFH to accomplish home visiting. In addition, staff in the current Olds' sites will receive continued training through PIPE (Partnering with Parents in Education) and through contact with the Kempe Prevention and Research Center in Denver, CO to teach pregnant mothers about the effects of early and regular prenatal care, or the lack of, on their unborn child.

The Missouri Community-Based Home Visiting Program (MCBHV), formerly the Families at Risk Program, will also undergo expansion in FFY 2001. Staff of the expansion sites along with the current six sites will be receiving Core Training from the Department along with Continuing Education seminars emphasizing the importance of early and regular prenatal care so that the staff in turn can educate their clients.

The Well Child Outreach program will distribute educational materials to families and professionals who have direct contact with families to promote the importance of preventive health screenings for pregnant women. Through collaboration with Medicaid, the program will provide outreach services for the Healthy Children and Youth program,

which offers comprehensive exams for children eligible for MC+ up to the age of 21. This also allows pregnant adolescents to obtain prenatal care through the Healthy Children and Youth program. The Healthy Babies program will distribute educational materials to families about the importance of first trimester entry into prenatal care, and will provide incentives to women who enroll in the program and begin care in the first trimester. Print materials, television and radio spots, newspaper supplements and keepsake books will carry a consistent message of the importance of first trimester entry.

SP 01: Percent of women with inadequate prenatal care.

This performance measure has been discontinued.

SP O2: Percent of inadequate birth spacing.

The Department of Health will address reducing the rate of inadequate birth spacing in FFY 2001 through preconceptional counseling in the Comprehensive Family Planning program, through education and outreach efforts, and through counseling and education incorporated in perinatal programs such as Home Visiting, Healthy Birth Outcomes, and Prenatal Case Management. All of the models of Home Visiting currently funded by the Bureau of Family Health teach their clients about the importance of adequate birth spacing and the effects of pregnancies less than 18 months apart. Expansion of these programs including funding for additional visits by Nurses for Newborns through the St. Louis County Health Department will further educate clients on this topic. The MCBHV program requires quarterly reporting of clients with birth spacing less than 18 months apart and will begin generating program wide reports including this statistic as part of its reporting. In addition, through the MCH services contract for FFY 2001, local public health agencies will provide education to promote adequate birth spacing and will refer clients for appropriate family planning care. Finally, the Healthy Babies program will use information obtained in a pre-campaign survey about birth spacing to design the educational messages needed to promote adequate birth spacing. Print and electronic media will offer consistent messages on preconceptional health and pre-pregnancy planning.

2. Children

The Department implements a population-based school health services program by providing funding to local public school districts and local public health agencies. The program is titled the Missouri School-Age Children's Health Services (MSCHS) program. The funding source is a current tax on tobacco products that has been available for school health programs since 1995. The contract with these agencies is structured to address specific child health objectives in the Department's strategic plan. In FY 2001, services will be provided in approximately 380 sites, including 98 private and parochial schools. More than 268,000 school-age children will benefit from routine and expanded school health services. This is an increase of more than 10% over the FY 2000 contract year. The main goal of the program is to increase access to health care. Contractors are required to identify children without insurance, and to facilitate referral to Medicaid or Missouri's child health insurance program, MC+ for KIDS.

MCH Mandated performance measures address identification of medical and dental homes, frequency of routine physical and dental care, management of special health care needs in the school setting, Hepatitis B immunizations in adolescents and surveillance of levels of obesity in school-age children. Elective measures include activities to address dental care and the six risk behaviors identified by the Centers for Disease Control and Prevention.

Preliminary evaluation has demonstrated that there is a positive effect on school attendance and an impact on drop-out rates. MSCHS contracts have been targeted to areas of high need, as defined by poverty levels, high nurse-to-student ratios, high absenteeism and drop-out rates. A second phase of evaluation in FY 2001 will further define school health services provided for children with special health conditions. In addition, the evaluation will begin to define best practices and continuing education needs of school nurses.

3. Children with special health care needs

03: The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."

All children with special health care needs require regular ongoing comprehensive care within a medical home. Exploration of providing physician training

about medical home and the promotion of its use in the community for family practice physicians is planned for FFY 2001. The medical home as the source of ongoing coordinated health care must be recognized as an organized, consistent and continuous means of providing primary care coordinated with specialty care and community resources for the infrastructure of health care services provided to children with special health care needs. It is important to recognize that many with severe health conditions who require medications, therapies and nursing services, are below the federal poverty level, and need social support in the community.

The BSHCN will continue to support a family-centered, community-based coordinated system of care linking families and physicians together. One such linkage occurs within the Healthy Children and Youth (HCY) program where an HCY Facilitator serves in each of the five district offices throughout the state. HCY Facilitators connect clients with Medicaid providers in order to provide access to care which helps them stay healthy or identifies special medical problems that may require treatment. This program's focus is on primary and preventive care and is one strategy to establish a link to a "medical home" where there was none before. In FFY2001, the BSHCN will review the role of the HCY Facilitator to assure priority is placed on assisting families in locating a medical home for their children and themselves.

While the method of capturing data for the "medical home" is not completed at this time, we plan to expand our capabilities within the scope of the MOHSAIC computer information system. In the interim, partial data can be obtained from our existing Missouri Computer Assistance Resource Enrichment Services (MOCARES) system for children enrolled in the CSHCN program, along with data from the Maternal Child Health (MCH) services contract with 112 Local Public Health Agencies throughout the state to project estimates. The MCH services contract for FFY 2000 required Local Public Health Agencies to report progress on this performance measure based on the expanded definition of children with special health care needs-those who are not enrolled in the CSHCN program because of not meeting Medicaid eligibility requirements. This same reporting will be required for the FFY 2001 contract. Data from 112 of 115 local public health agencies indicate a 20% prevalence of children with or at risk for special health care needs, and of these children, 78% have some form of health insurance and 30% aligned with a medical home. The BSHCN will initiate in-depth collaboration with the local health agencies to assure consistency in data

collection including: to clarify data sources, definition of terms, the data itself and the conclusions that may or may not be inferred relating to children with special health care needs.

Data obtained from the Child Care Resource and Referral Network inclusion coordinator services (those services provided to assist families of children with special health care needs in locating child care), will be assimilated and reviewed. This review will determine whether the child care needs of families accessing this service are being met as well as determining long range strategies required to meet families' child care needs at the community level and for the long range plans of this valuable program.

4.1.C. Population-based Services

SP O4: Percent of citizens drinking fluoridated water.

Missouri already exceeds the Healthy People 2000 and Healthy People 2010 goals regarding the percent of the population who are served by community water systems with optimally fluoridated water. However, the Bureau of Dental Health will continue to provide equipment, training and technical assistance for communities that want to adjust the fluoride level in their water through the Community Water Fluoridation Assistance Program. The dental health program will continue to meet with community leaders and the public to assist them in beginning or maintaining their fluoridation systems.

1. Pregnant Women, Mothers and Infants

04: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).

Missouri statutes require that all newborns in the state must be screened for phenylketonuria (PKU), and other metabolic and genetic conditions prescribed by the Department. In addition to PKU, screenings are currently performed for galactosemia, hypothyroidism and sickle cell anemia. Congenital adrenal hyperplasia is being considered by the Newborn Screening Standing Committee for addition to the required screenings done for all newborns. The Bureau of Disabilities Prevention and Injury Control assures follow-up services are provided for infants who test positive in the screening process.

05: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tentanus, Pertussis, Haemophilus Influenza, Hepatitis B.

The MCH Program, the Center for Health Information Management and Epidemiology, the Bureau of Nutrition Services and WIC, and the Section of Vaccine Preventable and Tuberculosis Disease Elimination will continue to participate in a pilot project, to increase the number of children and childhood vaccines administered that are entered into the central registry (MOSAHIC).

09: Percentage of mothers who breastfeed their infants at hospital discharge.

During FFY 2001, an initiative to increase the acceptance of breastfeeding, as a feeding norm for infants, will begin. Efforts will be made to include breastfeeding education into the curriculums of public schools and schools for health professionals. A concentrated media campaign using public service announcements will also begin in FFY2001. A primary focus in FFY2001 will be to increase the number of health professional organizations providing conference sessions on breastfeeding. Efforts to encourage women to breast feed will be continued in WIC clinics; access to electric pumps will be piloted with the expectation that the pilots will increase breastfeeding rates for high-risk infants.

The Building Blocks Program admits pregnant women to the Home Visiting program prior to the 28th week of pregnancy. A topic that will continue to be addressed through this prenatal education is the advantages to mothers and babies when mothers breastfeed babies. Expansion of this program will expand the number of pregnant women statewide that can be affected by this message. Staff of the Building Blocks program will attend the second seminar on Breastfeeding that will be hosted by The Bureau of Nutrition in the Fall of 2000 to gain further knowledge in this area.

10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.

In FFY00, the Bureau of Disabilities Prevention and Injury Control (BDPIC) continued to contract with Southwest Missouri State University to monitor the progress of the pilot project for universal newborn hearing screening. The data collected from the

pilot project aided passage of state legislation mandating statewide universal newborn hearing screening. In FFY01, BDPIC will add staff and implement a data management system to provide the support needed to fully implement the new statewide program. The additional support will allow the Department to: determine the incidence of hearing loss among newborns, ensure infants are referred for confirmatory audiological services, and provide training to hospitals about implementing a universal newborn hearing screening program.

SP 05: Percent of women who have reported smoking during pregnancy.

The Bureau of Family Health plans several initiatives for FFY2001 to reduce the percent of women smoking during pregnancy:

1. The Missouri prenatal drug (alcohol, tobacco and other drugs) prevalence study will be completed in 2001. Results will be compared to the 1993 and 1997 prevalence studies to determine trends in patterns of usage;

2. The Bureau of Family Health's Perinatal Substance Abuse Program, in collaboration with the Departments of Elementary and Secondary Education, Mental Health and other agencies, will continue providing training and education to health professionals to help them assess and implement perinatal smoking cessation programs;

3. A statewide campaign to educate health professionals on use of the "Agency for Health Care Policy and Research's Clinical Practice Guidelines on Smoking Cessation" will be conducted in collaboration with the Centers for Disease Control's education grantee developmental systems;

4. The BFH plans to conduct a collaborative research study with the University of Missouri Sinclair School of Nursing to determine if a cost-effective, telephone social support intervention will assist pregnant women's smoking cessation efforts by addressing/reducing stress factors that make it difficult for pregnant women to stop smoking;

5. The BFH is also working with Bureau of Nutrition Services and WIC to implement smoking cessation programs in WIC clinics and with Medicaid Managed Care plans to encourage providers to assess client smoking as a fifth vital sign. The Department will also maintain or expand educational components of all prenatal

programs to include the risks of smoking during pregnancy, and ensure referral and education for smoking cessation resources;

6. The Well Child Outreach program will provide education to families and professionals who have direct contact with families about the importance of avoiding tobacco while pregnant and protecting infants and children from being exposed to secondhand smoke;

7. The Healthy Babies program will emphasize the importance of avoiding tobacco while pregnant. Print materials, television and radio spots, newspaper supplements and keepsake books will carry a consistent message about the negative effects of tobacco on the developing fetus and secondhand smoke on the infant;

8. The current Home Visiting programs contain standard curriculum to educate mothers on the effects of smoking during pregnancy. Referrals to "Smoking Cessation " programs will continue to be made. All of the programs will report on a monthly basis the number of mothers who are smoking and the number who have decreased their smoking. Comparisons of programs will be done to evaluate effectiveness of teaching methods among the home visiting programs;

9. Finally, during each client's initial and annual Comprehensive Family Planning visit, clients will continue to be assessed for tobacco, alcohol and other drug use. Education and/or referral will be provided as indicated.

2. Children

06: The birth rate (per 1000) for teenagers aged 15 through 17 years.

Comprehensive Family Planning services are available to all Missouri residents who are of reproductive maturity, do not have Medicaid coverage, or are not insured for reproductive health services. Contraceptives, education relating to safe sex, and education regarding use of contraceptives are offered.

The Alternatives to Abortion program offers services to pregnant women of all ages. Women at risk of having an abortion are offered case management services to abate the risk of abortion.

The Missouri School-Age Children's Health Services program includes an opportunity for contractors to address sexual behaviors in adolescents. The Department will continue administering the Abstinence Only Education project supported by the Abstinence Education Provision of the 1996 Welfare Law, P.L. 104-193, Section 510 of

Title V of the Social Security Act. Since 1998, the Department has offered support for school and community-based abstinence only education programs. Program priorities include abstinence only education in 5th-8th grades and parent/child sexuality education. Currently, nineteen (19) contractors implement abstinence only education programs in more than 80 school and community settings. It is anticipated that additional contractors will be funded in FFY 2001-2002. In addition, the General Assembly passed legislation (SB 163), effective August 1999, requiring school districts providing sexuality education to involve parents in the selection of curricula, and to emphasize abstinence above all other information. The Department is exploring the possibility of an interagency agreement with DESE to offer abstinence education training to all public school district Family and Consumer Sciences (FACS) teachers statewide during FFY 2002. Another strategy being explored is the development of a statewide media campaign. The combination of these activities is expected to impact Missouri's adolescent pregnancy and teen birth rates.

07: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Missouri's dental health program will continue initiatives to increase the number of children with sealants by providing education to parent, children, providers, and others, and by providing sealants for vulnerable populations who do not have access to care.

While schools are the primary focus for sealant application, the Bureau of Dental Health will continue to work with local communities to support dental clinics in local health agencies and other community health centers. The advent of state children's health insurance program two years ago made an estimated 90,000 additional children eligible for sealants. However, due to the inadequate capacity of the Medicaid provider system, most children have not been able to access dental services through the program. As a result, the Bureau of Dental Health's program will continue to provide sealants for about 5000 children per year, through a combination of school based and school linked programs. The Bureau of Dental Health will also continue to work with the Division of Medical Services (the Medicaid agency) to increase access to oral health services throughout Missouri.

The Missouri School-Age Children's Health Services program also promotes access to routine dental care, and provides funding for dental services for children who do not qualify for Medicaid or MC+ programs and whose family cannot afford care. Contractors are required to identify children who have a family dentist, and who have had maintenance care in the last 12 months.

Elective performance measures within the MCH Services contract also address oral health issues. Contractors can elect to promote dental sealant programs, and to identify students with untreated dental caries and attempt to facilitate care.

08: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

The Missouri SAFE KIDS Coalition, supported by the Bureau of Disabilities Prevention and Injury Control, is dedicated to the prevention of unintentional injuries for all children ages birth to 14 years. The state coalition provides technical support to seven local SAFE KIDS coalitions that conduct injury prevention activities in 52 Missouri counties. Motor vehicle occupant safety, bicycle and pedestrian safety strategies of the SAFE KIDS coalitions include: providing educational materials concerning safety seat installation and usage; hosting child passenger safety seat check events; providing safety seats to low-income families who do not have a seat or have a defective seat; and providing bicycle and pedestrian safety instruction to children. SAFE KIDS coalitions participate in community events including safety fairs and utilize local media in distributing prevention messages.

The BDPIC also supports the Missouri THINK FIRST program, a head and spinal cord injury prevention program at the University of Missouri Columbia. THINK FIRST conducts prevention programs in schools for children of all ages and for driver education programs. Prevention programs are targeted at motor vehicle crashes, as well as the other leading causes of head and spinal cord injury. The Missouri Injury Control Advisory Committee meets quarterly to address injury issues and advise the Department on current injury related concerns and objectives. The BDPIC also participates in quarterly regional injury prevention teleconference calls with the National Highway Transportation Safety Administration.

In FFY 2001, the BDPIC will continue to expand educational efforts, increase interagency collaboration, and promote safety throughout the state. The BDPIC will

support coordination between the Department of Health, the Division of Public Safety and other agencies concerned with the prevention of unintended injuries.

In addition to BDPIC efforts, the Missouri School-Age Children's Health Services (MSCHS) program has stressed safety education that is developmentally and age-appropriate. MSCHS contractors can elect to provide safety education such as seat belt usage, bicycle helmets and safety and pedestrian safety. Safety education is also a focus of the Child Care Health Consultation program administered by the Bureau of Child Care. Health Consultants frequently provide education to child care providers, children and their families about child safety seats, seat belt usage, bicycle and pedestrian safety.

SP 03: Percent of low income children ages 1-11 who consume nutritionally adequate diets.

In FFY 2001, data will be collected on physical activity to begin addressing obesity in children. Physical activity, anthropometric data and dietary data will be cross-matched and used in interventions to reduce the obesity risk factor for children. Baseline data for calcium, fruits, and vegetables consumed by children over age 2 will be obtained. Additional efforts will be made to increase the accessibility of nutrition data and education materials. Participation in WIC, the Child and Adult Care Food Program, the Summer Food Service Program, and the Farmers Market Nutrition Program will be increased in FFY 2001. Steps will be taken to improve the effectiveness of nutrition education targeted to caregivers of children participating in WIC and school.

Dietary intake data collected from school age children using a food frequency questionnaire (FFQ) will be expanded. In addition, steps will be taken to improve the capacity of the schools to accurately analyze height and weight and dietary intake, and to improve the school nutritional health services by providing training and resources. Ways to assure health care access for students with nutritional problems will be identified.

Missouri School-Age Children's Health Services contractors are required to provide follow-up for children who have been identified as having weight for height outside the norms for their age. This follow-up includes assessment of diet and referral to a health care provider, if indicated. This initiative has been formalized by mandating that contractors weigh and measure fifth-graders and assess diets. In FY 2000, the first

year of the program, the physical growth of more than 20,000 fifth graders was assessed. More than 20% of these fifth graders had Body Mass Index rates outside the norms for their age. FFQs were obtained on students who were outside the norms, FFQs were analyzed for adequacy and referrals made to health care providers. In FY 2001, this program will be expanded and FFQs will be obtained on all students who are weighed and measured.

3. Children with special health care needs

Several initiatives to address children with special health care needs will be implemented in FFY 2001. CSCHN funding allocated to school health programs will be used to provide continuing education for school nurses, school social workers and school counselors on issues identified by Title V as special health needs. An evaluation of services provided in schools will be used to guide the content of the continuing education programs. In addition, funding will be used for Enhancement Projects that will enhance the ability of agencies to provide services for children with special health needs in the school setting. This will include purchase of equipment, in-service education for school staff and contracted services for children and families.

4.1.D. Infrastructure-Building Services

SP 06: Percent of MC+ Managed Care Organizations (MCOs) utilizing MCH data.

MCFH will continue to provide staff support for the MC+ Quality Assessment and Improvement MCH Sub Group. All managed care plans participating in the MC+ Medicaid program currently use MHC data to target services to MCH population groups in an attempt to impact he MCH health status indicators. The MCH Sub Group will continue to function in FFY 2001 as in the past.

1. Pregnant Women, Mothers and Infants

15: Percent of very low birth weight live births

The Bureau of Family Health will continue to promote early prenatal care and funding for interventions aimed at reducing very low birth weight babies. Plans for FFY 2001 include the following: BFH, in cooperation with other bureaus and agencies, will develop and promote a statewide campaign to increase public awareness about programs and resources available and to increase the number of pregnancies that result

in healthy babies, including the risks of: domestic violence; genetic disorders; inadequate exercise; inappropriate weight gain; infection; and substance abuse. The Department will continue to update the TEL-LINK database and assure access to support services for pregnant women including case management, prenatal care, counseling, and other health and social services. The bureau will also continue to promote education, counseling and service coordination for pregnant women regarding the use of alcohol, tobacco and other drugs through such programs as prenatal case management and perinatal substance abuse.

The Healthy Birth Outcomes program will focus on supporting the efforts of local communities in seven high risk areas to reduce low birth weight babies and infant mortality by implementing interventions that target specific, evidence-based factors modifiable during gestation, such as substance abuse, smoking cessation, and folic acid, and by collaborating within the community to provide culturally competent, appropriate services. The contractors for the Healthy Birth Outcomes program will collaborate with Missouri's Healthy Start sites to provide culturally competent community education regarding the impact of low birth weight infants. Also in FFY 2001, the BFH will sponsor a statewide infant mortality reduction conference that will address the related factors and impact of low birth weight infants. The Department will maintain and expand culturally competent literature designed to educate the public on the impact of low birth weight infants. Further plans include providing one time funding to establish an evidence based, self-sustaining fathering program to increase the father's support and positive involvement with the children and families in a high risk county**.** This program will provide community sites with trained individuals to initiate the program objectives and services and will continue to provide sites with support needed to sustain them in the form of education, problem solving, community collaboration, funding and referrals.

Finally, BFH will provide funding for a one time research study to determine the standard of care evidenced in hospital policies and practiced behaviors of hospital nurses regarding newborn sleep position.

17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The Healthy Birth Outcomes program works to identify pregnant women at risk for delivering very low birth weight infants; provides assistance to women in accessing

health care during pregnancy; and communicates with women's health care providers about the need for high-risk delivery hospitalization.

18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester:

The Bureau of Family Health will collaborate with community agencies to conduct outreach activities designed to identify pregnant women at risk of not receiving adequate prenatal care. The Healthy Birth Outcomes sites will continue to collaborate with the Division of Medical Services to process Temporary Medicaid during Pregnancy (TEMP) applications for pregnant women, and to emphasize early prenatal care through individual counseling, home visits, and community education. The Perinatal Substance Abuse program will work with local drug and family courts to promote a supportive health/rehabilitative model of care for pregnant women engaged in substance abuse. Collaboration between the courts and health care providers is critical to assure substance-abusing women continue to seek and persist with prenatal care.

Expansion of the Building Blocks and MCBHV programs will assure more pregnant women receive prenatal care beginning in the first trimester. Through the home visiting programs, pregnant women will have access to referrals for community resources, including prenatal care and insurance. Preconception care, offered through the Comprehensive Family Planning Program, impacts the frequency of pregnancy, birth spacing, and increases timely referrals for prenatal services. Preconception education, information regarding the importance of folic acid for prevention of neural tube defects, and infertility information are also provided by the Comprehensive Family Planning program. Finally, prenatal care is offered through the Alternatives to Abortion Program. When a pregnant woman is identified to be at risk for having an abortion, she is eligible to receive case management services and coordination of prenatal care and other services designed to abate the risk of abortion.

2. Children

The Department implements a population-based school health services program by providing funding to local public school districts and local public health agencies and is titled the Missouri School-Age Children's Health Services (MSCHS) program. The funding source is a current tax on tobacco products that has been available for school

health programs since 1995. The contract with these agencies is structured to address specific child health objectives in the Department's strategic plan. In FY00, services are provided in 340 individual school sites, including 88 private and parochial schools. More than 240,000 school-age children benefit from routine and expanded school health services. It is anticipated that approximately 25,000 more children will benefit from FY01 contracts. The main goal of the program is to increase access to health care. Contractors are required to identify children without insurance, and to facilitate referral to Medicaid or Missouri's child health insurance program, MC+.

Mandated performance measures in the contracts address identification of medical and dental homes, frequency of routine physical and dental care, management of special health care needs in the school setting, Hepatitis B immunizations in adolescents and surveillance of levels of obesity in school-age children. Elective measures include activities to address dental care and the six risk behaviors identified by Centers for Disease Control and Prevention.

Preliminary evaluation has demonstrated that there is an increase in school attendance and a decrease in drop-out rates. Contracts have been targeted to areas of high need, as defined by poverty levels, high nurse-to-student ratios, high absenteeism and drop-out rates. A second phase of evaluation will further define care for children with special health conditions.

12: Percent of children without health insurance

The Department is currently working with the Department of Social Services and the MC+ Advisory Committee to coordinate eligibility and enrollment outreach efforts with schools, hospitals, and local public health agencies by identifying and limiting barriers to Medicaid (MC+) enrollment. The MC+ and other Medicaid benefit packages are being evaluated to determine the role the Division of Maternal, Child and Family Health may have in continuing to provide services to children in Missouri who do not qualify for Medicaid and do not have private insurance. Finally, the MCH services contract for FFY 2001 will require local health agencies to monitor and report progress on the number of children with insurance.

The MSCHS program requires contractors to identify children without health insurance and to facilitate referrals to Medicaid and MC+ for KIDS programs. Contractors are routinely provided information about the MC+ for KIDS program, and all

school nurses receive information about MC+ for KIDS through a school health newsletter prepared in collaboration with the Department of Elementary and Secondary Education. MSCHS contractors will continue to be encouraged to promote the MC+ for KIDS program in their communities and among other school staff.

13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

The Department will continue to conduct outreach activities to increase awareness about the children's health insurance program and the importance of obtaining preventive and primary care for children and adults. Contracts with local public health agencies will facilitate outreach in local communities to enroll children in MC+ for Kids and to encourage well child exams and other preventive and primary care medical and dental services. The SHCN service coordination system will continue to coordinate services for children with special health care needs. TEL-LINK will also continue to link families with health providers and Medicaid.

16: The rate (per 100,000) of suicide deaths among youths 15-19.

The Department is working collaboratively with consumer representatives and the Departments of Mental Health, Corrections, Social Services, and Elementary and Secondary Education to develop a long-range plan to enhance suicide prevention efforts in Missouri. The statewide, multi-agency plan will be completed by September 2000 and will include strategies each agency will address in future years. The Department will begin implementation of strategies in FFY2001. In addition, the Department will continue to engage in community-based activities, such as survivor group and resource identification, and the development of gatekeeper training for professionals who may have interactions with individuals at risk for suicide.

In addition, the statewide Adolescent and School Health Task Force may begin addressing suicide initiatives. There is general agreement that there is an unmet need for situational and short-term mental health intervention with adolescents. Few schools implement a suicide prevention curriculum but address the issue through student assistance programs and peer education. The Department of Mental Health provides limited services for children and adolescents with suicidal ideation, but all mental health services for this group are severely under-funded. The Missouri School-Age Children's

Health Services program identifies students with mental health concerns, and works to provide access to care including payment of services.

School nurses, school counselors and school social workers will be invited to attend a summer conference on the role of school personnel in suicide prevention. MSCHS contractors use funding to provide mental health services including assessment, diagnosis and treatment. Some contractors employ licensed clinical social workers who can provide individual and group therapy.

SP 07: Percent of children under age 2 with a reported subdural hemotoma.

This state negotiated performance measure has been eliminated due to insufficient data.

SP 08: Percent of child care facilities receiving health consultation.

The Bureau of Child Care (BCC) will continue to contract with local public health agencies statewide to conduct health consultation with child care providers in their communities. In addition, the BCC will continue to monitor consultation services and provide ongoing professional development opportunities to the local child care health consultants. During FFY01, training will be provided to local health consultants regarding the care of children with special needs relevant to child care settings. This training will be conducted in collaboration with the Center for Innovations in Special Education and the First Steps (Part C - early intervention) system. The BCC will coordinate collaboration among local health agencies, the Missouri Child Care Resource and Referral Network, and other agencies providing consultation and training to child care providers.

3. Children with special health care needs

11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

The BSHCN will continue to place emphasis on referring families to MC+ and other Medicaid programs when they do not have private insurance to cover primary and specialty care services. When individuals enrolled in the CSHN program do not have access to public or private insurance, the CSHCN program will continue to provide funding for approved services. The BSHCN will continue to facilitate referrals through

the service coordination network by directing people to programs for which they are qualified, such as Medicaid and the MC+ program. Due to MC+ and Medicaid outreach efforts, it is expected that the number of children qualifying for and enrolled in the state CSHCN program will continue to decrease. While the impact of Title XXI on the state CSHCN program is expected to continue for FFY 2001, BSHCN will continue to assure children with special health care needs have medical homes and appropriate health insurance coverage.

Through cooperative agreements for broad based insurance coverage, the BSHCN will continue to work with the Departments of Mental Health, Social Services, and Elementary and Secondary Education to share information on service gaps, develop strategies and change policies to reduce and eliminate service gaps. In addition to BSHCN efforts, the FFY 2001 Maternal and Child Health (MCH) services contract, 30% of the contract award must be used for services related to children with special health care needs.

14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

During FFY2000, the BSHCN conducted a survey of families with children enrolled in the CSHCN program. The study revealed the Bureau does meet the needs of families and children, however, the BSHCN needs to involve families in redefining the policies and programs that serve children with special health care needs.

The BSHCN currently encourages family participation in the Genetics Disease Advisory Committee, the Head Injury Advisory Council, First Steps State and Local Interagency Coordinating Councils, and other small work groups which inform the Bureau about various special health care needs issues. The goal of the BSHCN is to promote family centered services by: expanding and enhancing current committees to include more family members; involving stakeholders, including families, in statewide policy development; offering training, mentoring and reimbursement assistance to those who participate in task force work; and working with stakeholders on committees designed to facilitate discussion of services required for children with special health care needs.

BSHCN is in the process of implementing a system where families of children with special health care needs participate in public and private partnerships which

impact the alignment of services with core public health functions. This process will include organizing stakeholders to review medical eligibility and benefit packages, evaluating program effectiveness, and studying related models from other states.

In FFY 2001 the BSHCN will continue to provide opportunities for families with special needs children to attend training and educational conferences as a method to encourage families to communicate and share their experiences. The BSHCN will continue to offer families the opportunity to assist in determining priorities and strategies to ensure that children with special health care needs receive quality care, particularly as they transition and enroll in MC+ or other insurance programs.

The BSHCN will continue to work with DSS to provide education to BSHCN staff, local health agencies, and DSS staff about the risk of child abuse and neglect in special needs populations. The BSHCN and DSS will also address unresolved issues relating to effective reporting of abuse and neglect.

The lack of private duty nurses, personal care aides, advanced personal care aides, and respite care providers is a priority issue the BSHCN will continue to address through collaboration with DSS.

4.2 Other Program Activities

This section of the Annual Plan describes those activities within each level of the pyramid not discussed in Section 4.1.

4.2.A Direct Medical Care

Sexual Assault Prevention Four programs will address Sexual Assault Prevention in Missouri for FFY 2001: Sexual Assault Prevention Services, Sexual Assault Victim Services, Sexual Assault Forensic Evaluation-Child Abuse Resource and Education (SAFE-CARE) Network, and Rape Medical Examination Program. Although the MCH Block Grant does not fund these programs, they do support activities that aim to improve primary or preventive health services for women and children.

Sexual Assault Prevention Services are primarily implemented through contracts that are awarded statewide to provide preventive sexual assault educational programs for Missouri citizens to decrease sexual assault and abuse. This federal funding through the Preventive Health Services Block Grant and Omnibus Crime Bill will continue to support several additional projects for FFY 2001, including the Missouri Coalition Against

Sexual Assault (MoCASA) Administration. Plans for FFY 2001 also include collaboration with the University of Missouri-Columbia to develop a standardized sexual assault prevention curricula for junior and senior high students in the state of Missouri. This project will provide ongoing training for sexual assault prevention education contractors. By standardizing prevention education programs and improving the quality of presentations, the Department hopes to more effectively protect the safety of Missouri's children in the area of sexual violence.

Sexual Assault Victim Services are also implemented through contracts that are awarded statewide to provide direct services for victims of rape and sexual assault to assist in recovery from the trauma of sexual assault and to prevent secondary victimization.

Medical direction, administration, and data entry for the SAFE-CARE Network will continue to be contracted to the University of Missouri-Columbia. The purpose of the Network is to provide comprehensive training and medical consultation for the benefit of Missouri medical providers to improve the quality of medical evaluations for the alleged child victims of sexual assault, physical abuse, and neglect. Plans for FY 2001 include continued expansion of and quality assurance within the Network to assure adequate evaluation of children who are victims of abuse or neglect. This will include ongoing collaboration with the Department of Social Services to improve linkages with the Child Abuse and Neglect Hotline database.

The Rape Medical Examination Program reimburses qualified medical professionals for forensic medical examinations after a rape, sexual assault, or sexual abuse for the benefit of victims who do not have Medicaid, Medicare, or private insurance that covers the cost of the examination.

First Steps. First Steps is Missouri's early intervention system under Part C of the Individuals with Disabilities Education Act (IDEA). While the Department of Elementary and Secondary Education is the lead agency for First Steps, the Bureau of Special Health Care Needs and the Department of Mental Health provide assessment and service coordination services. Currently, children are eligible for First Steps between birth and 3 years of age, have a delay of 50 percent or more in one area of development or a diagnosed condition that is associated with developmental disabilities. The First Steps system has been undergoing an extensive review which is resulting in a major redesign of the system. During FFY2001, a provider credentialing system will be

implemented and central finance office will be established. The system redesign has occurred to assure service delivery in the child's natural environment, assessments that are needs-based and age appropriate, and greater parental involvement in treatment decisions.

Head Injury Services Program. The Missouri Head Injury Services Program typically provides services for adults over the age of 21 with traumatic brain injury (TBI). Missouri will continue to make services available for the adolescent with traumatic brain injury in particular, services that will enhance independence and community reintegration. Services to adolescents include service coordination and funding for rehabilitation and support services in the community.

4.2.B Enabling Services

Assessment of Women for Intimate Partner Violence (IPV) The Department of Health is developing several initiatives to address IPV as a serious health issue and public health problem. First, the Department is sponsoring a conference, Domestic Violence: A Health Care Imperative in July 2000 to inform health care professionals working with women, children and families of the health consequences of IPV. The goal of the conference is to strengthen health care's response to IPV by presenting science-based, field-tested solutions regarding the health consequences of IPV and interventions to address the issue. Leading researchers in the field of IPV will be presenting the latest information regarding IPV to Missouri's health care community. The target audience for this conference is staff working in local public health agencies, family planning clinics, and managed care organizations.

A second Department IPV project involves working with the hospital association, a health plan, the domestic violence advocacy group and the health information management association to provide two statewide training initiatives. The first is to train staff working in emergency rooms to recognize, document, and refer individuals experiencing intimate partner violence into a system of care. The second will be to sponsor training for experienced hospital coders to improve the quality and quantity of hospital E coding.

Finally, the Department will partner with professionals on a statewide basis who have regular contact with families and children to provide training related to IPV and its impact upon children. The target audience for this initiative includes teachers, child care

workers, health and mental health care providers, law enforcement officers, child welfare workers and court personnel.

Pediatric Leadership Alliance. During FFY2000, the Pediatric Leadership Alliance (PLA) Team will select a number of pilot sites using Head Start, Local Health Agencies, community child care providers and health care providers as the hub for assuring children have medical homes and access the medical, dental, and mental health care needed. In FFY2001, the PLA Team will work with the pilot sites to: understand the medical home concept; determine common goals and develop an operational plan; provide technical assistance for implementation; monitor progress in achieving common goals; evaluate the effectiveness of the project; and report to stakeholders about achievements. Outcomes that are expected are children in child care will have health insurance, a usual source of medical and dental care, current immunizations, and complete EPSDT screenings.

Alternatives to Abortion. The Alternatives to Abortion program provides a comprehensive, coordinated system designed to maximize access to needed services for pregnant women at risk of pursuing abortion services. Since January, 1998, the Department of Health has contracted with community-based organizations for the provision of direct services, including case management for pregnancy maintenance, prenatal care, ultrasound services, housing, alternative schooling, job training and placement, efforts to promote responsible paternity, adoption assistance, drug and alcohol testing and treatment, domestic abuse protection, transportation, medical care, newborn or infant care, child care, and parenting skills. Contracts will be continued in FFY2001 and outcome data from these contracts will be assessed.

Service Coordination for Children with Special Health Care Needs. Service Coordination is available for children and families with special health care needs on a limited basis in Missouri. While service coordination is available for those enrolled in BSHCN programs, specific program limitations, coupled with the mix of eligible individuals is demonstrating that a network of service coordination extended into the community is needed. The BSHCN will decentralize service coordination and develop contractual relationships with community based local public health agencies to assure service coordination is available to children with special health care needs. Extension of the service coordinator network will strengthen the communication at the local community level and assist with strengthening the available resources for those families.

Community based service coordination systems will give and collect information from individuals to find children with special health care needs, determine eligibility for services, refer and participate in the authorization of services, and follow-up aftercare is delivered. This effort will require training and technical assistance from experienced service coordinators and assurance that the network is effective in meeting the families needs as a member of their community.

The Juvenile Arthritis Service Coordination Project. The Division of Chronic Disease Prevention and Health Promotion and the Division of Maternal, Child and Family Health jointly contract with the Missouri Regional Arthritis Centers (RAC) for service coordination for children with juvenile rheumatic diseases. Service coordinators help families identify, locate, obtain, and coordinate needed services in their home community.

Children's Healthcare Options Improved through Collaborative Efforts and Services Program (CHOICES). CSHCN program participants may access the CHOICES Program for facilitating care coordination between public and private agencies. CHOICES is designed to optimize the use of the resources that are available to children with special needs nationally. The BSHCN participates in the CHOICES program with one-half time equivalent position designated for care coordination activities through the Shriner's Hospital in St. Louis, Missouri. During FFY 2001, the BSHCN will continue to engage Missouri's vocational rehabilitation staff in the collaborative effort to assure children with special health care needs are screened and referred to CHOICES when appropriate.

Child Care Resource and Referral Services for Children with Special Needs. During FFY2000, the Missouri Child Care Resource and Referral (R&R) Network employed Inclusion Coordinators to assist families of children with special needs find quality child care. Inclusion Coordinators provide: education for families about finding quality child care, the benefits of inclusion, and community resources; referrals to other systems that support individuals with special needs; and assistance to the families and child care providers to develop a plan for meeting the child's needs in child care. Inclusion Coordinators also provide technical assistance and training for child care providers about caring for the individual needs of the children in their care. During FFY 2001, targeted services will continue for families and child care providers caring for children with special needs. The R&R Network will collaborate with community partners

and statewide agencies to advocate and facilitate the inclusion of children with special needs in child care.

4.2.C Population Based Services

Infant Mortality. Three separate programs will address infant mortality in Missouri in FFY 2001: Healthy Birth Outcomes programs, Professional Education for Infant Mortality Reduction and home visiting programs. Healthy Birth Outcomes efforts include community based projects designed to promote healthy birth outcomes and reduce the disparity between the black and white infant mortality rates in areas of high disparity. The Healthy Birth Outcomes program will focus on supporting the efforts of local communities in seven high risk areas to reduce infant mortality by implementing interventions that target specific, evidence-based factors modifiable during gestation, such as substance abuse, smoking cessation, and folic acid, and, by collaborating within the community to provide culturally competent, appropriate services.

Professional education. The Department contracts to provide training for health professionals about ways to reduce infant mortality such as sleep position, maternal age, smoking cessation and breastfeeding. The goal of this contract is to support the education of health professionals who may impact factors leading to healthy pregnancies and positive birth outcomes through direct care and patient education.

Perinatal Substance Abuse. The Bureau of Family Health's Perinatal Substance Abuse Program, in collaboration with the Departments of Social Services, Mental Health, Elementary and Secondary Education, and other agencies, will continue providing education for health professionals to asses and implement perinatal substance abuse cessation programs. Target areas for education include: gender specific treatment, needs of the drug exposed child across the life-span, assessment skill building and fetal alcohol syndrome.

TEL-LINK is the Missouri toll-free telephone line for maternal, child and family health services. The purpose of TEL-LINK is to provide information and referrals to Missouri residents concerning a wide range of health services. Callers are given referrals and then are transferred immediately to the appropriate agency. Since August 1991, TEL-LINK has received over 34,400 calls. In SFY 99 a statewide, comprehensive multi-media outreach campaign for TEL-LINK, with particular emphasis on families and high-risk populations was conducted. The TEL-LINK number was used to promote a

statewide information campaign to inform Missourians about the State Children's Health Insurance Program (MC+) and how eligible children can be enrolled in this initiative. The TEL-LINK database was updated to include resources related to MC+ and other new public and private programs. We will continue to collaborate with other state agencies, bureaus within the Department of Health, and other entities and continue to do community and professional outreach to promote the TEL-LINK number.

Healthy Children and Youth Program (HCY), is Missouri's name for the nationally known Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The BSHCN, through an inter-agency agreement with the Department of Social Services (DOSS), Division of Medical Services (DMS), provides service coordination and administrative case management, to those on Medicaid who are in need of home based medically necessary Medicaid services. The treatment services include assisting Medicaid recipients in accessing a primary care provider to obtain an HCY periodicity screen and appropriate interventions such as immunizations. The BSHCN provides service planning, service identification, prior authorization for medically necessary services identified for children with special health care needs, service monitoring, referral, and realignment of the service plan. This process facilitates medical home identification and connection to health providers. During FFY 2001, the evaluation of the current process of authorizing and providing services requires review in relation to the new Olmstead Act decision regarding meeting the needs of individuals with special heath care needs coming out of institutional arrangements and moving into their homes.

In addition, the regular HCY Case Management program is facilitated by BSHCN through training to the local public health agencies and case managers throughout the state. Data provided by DOSS indicates provider availability is limited even with provider recruitment efforts. The department has recognized a need to increase the number of HCY providers for EPSDT screenings, dental care, orthodontists, private duty nursing, and personal care services and is increasing HCY targeted case management. This provides local service coordination for children in need of HCY screening designed to provide periodic primary and preventive health services to Medicaid eligible infants, children and youth. The intent is to identify and treat health problems through the program's major components by informing individuals about the HCY program; referring for periodic screenings; providing service coordination for children and youth to obtain

services identified through screening; and assessing the adequacy of medical care and services provided through Medicaid.

The HCY program offers a service coordination system in which all family members are encouraged to assist in identifying needs and desired outcomes. BSHCN has implemented a process for sibling identification in conjunction with participant, by the facilitator in each area office to provide assistance and coordination with eligible clients.

Transitioning of HCY participants to adult programs is a focus of training and procedure for the BSHCN in FFY 2001. Program managers within the BSHCN are collaborating to define necessary changes to program policy/procedure to facilitate transition in a timely and effective manner. In addition, a study will ensue to reconcile authorized vs. actual delivered units of service by the provider. This utilization management study of providers will assist in determining appropriate resource allocation and distribution of funds as well as identify shortages of nursing services throughout the state. In FFY 2001, the BSHCN will continue revising the review process of family requested appeals for denied home based nursing services. This effort is to increase customer friendliness for the appeal of services considered not medically necessary.

Additional HCY program components that the BSHCN will address in FFY 2001 include increasing the medical monitoring of children enrolled in the HCY program for advanced medical support. By working collaboratively with the DMS in FFY 2000, the BSHCN developed a tool for assessment of the appropriate level of care for private duty nursing and a DMS-approved procedure for use of the assessment instrument. During FFY 2001 the BSHCN will be implementing an approved instrument and procedure to increase medical monitoring. Policy development for assessing necessity of personal care services is planned with assistance from DSS, DMS and Division of Aging (DOA.) HCY workgroups are continuing to establish policy for administrative case management, standards for performing administrative case management and a concise manual for implementation of the process. BSHCN continues to work collaboratively with DMS to assure statewide implementation of this service.

Data. A survey of families in managed care who have transitioned from the CSHCN Program to Missouri Medicaid Managed Care through the State Children's Health Insurance Program (SCHIP) is planned for 2001. Survey efforts, targeting children with special health care needs who have transitioned from the CSHCN program into the expanded Medicaid, MC+ for Kids program, will assist us in assuring that

specialty and primary care services are provided sufficiently for this population. This will assist in determining gaps in services that exist for these children and their families. BSHCN plans to identify opportunities to enhance services for children with special health care needs provided by the Missouri MC+ for Kids program as well as by the CSHCN program in order to provide greater access to services otherwise unavailable to the population. The survey will also identify, for providers at all levels, opportunities to enhance the services provided to better meet the needs of families and children with special health care needs. It will assist in identifying opportunities for BSHCN to assess policy changes to provide greater access to services for children with special health care needs and opportunities for statewide policy changes to improve the quality of care and services to children with special health care needs.

The BSHCN is participating in the Centers for Disease Control (CDC)'s national survey taking place from FFY2000 to FFY2001 with information available in FFY2002. This telephone survey will assist the state in obtaining pertinent data regarding the prevalence of families who have children with special health care needs. The CSHCN program can benefit from the information by reviewing its eligibility criteria to see if it meets the needs of the children with special health care needs population in Missouri. Recognizing the survey's limitations, the bureau may need to accommodate families that have no phone access by another means. This will provide a data set on 1500 families who have children with special health care needs in Missouri

4.2.D Infrastructure-Building Services

Adolescent Health Initiative. The Missouri Adolescent and School Health Advisory Task Force advises the Bureau of Family Health on a wide range of adolescent and school health issues, initiatives and funding priorities. The task force recommended the department support the development of community based "parenting your adolescent" projects. Eleven school and/or community-based projects have been funded. In 2001 this multi-year initiative will continue and funding will be requested to support additional projects. These projects will assess adolescent and community assets, use data to plan and implement evidence-based strategies and evaluate outcomes.

Another strategy is to develop an increased focus and expertise on healthy adolescent development in health care systems. To accomplish this, a statewide bi-

monthly newsletter will provide professional education for health providers by focusing on timely adolescent medicine issues and practices.

The Department's strategic plan includes a key objective "to improve the overall health of adolescents by 2006." This will require continued collaboration among DOH programs, other state agencies and community partners. An integrated adolescent health plan will be developed to address increased coordination of resources, activities and strategies to impact major factors that affect adolescent health.

Dental Health Access. The Bureau of Dental Health will continue efforts to collaborate with the Division of Medial Services to review and support increases to the Medicaid rates for reimbursing dental practitioners who provide services to children enrolled in MC+ and other Medicaid programs. The Bureau of Dental Health will also continue to be involved in an outreach program to encourage dentists and other oral health professionals to become participating Medicaid providers in their local communities. Funding for local communities to establish dental clinics will continue to be available in FFY2001. Funding may be used to purchase equipment to establish dental clinics.

Data Management, Information System. Missouri's transition from the existing MOCARES information system to the MOHSAIC information system has a variety of system and capacity issues under resolution at this time. Investigation into available provider resource modules to tie into the case coordinator system is being pursued. This will also influence the system selected for provider reimbursement. Specifically, the implementation date for the care coordination component is October 2000. New BSHCN components will continue to evolve after this date while enhancement and linkage with local public health and physician provider components are under development. Assessment of data elements required for the computer information system (MOHSAIC) for the BSHCN and development of security protocol is underway for transition from the current system (MOCARES). Missouri's transition from the existing MOCARES information system to the MOHSAIC information system is scheduled for January 2001. Workgroups are being formed for various stages of implementation. This statewide system will provide case data to local and state agencies serving families. This will promote productivity and create efficiency for better serving the special health care needs populations in Missouri. Because of its nature, information gleaned from the comprehensive database will be more accessible to allow local planning with state

support. MOHSAIC will provide a mechanism to obtain data and disseminate information to and from local health agencies regarding children with special health care needs. Agencies such as schools, child care and public health can benefit from a centralized data management system within the BSHCN.

Child Care Training and Professional Development. The Bureau of Child Care contracts with various organizations to conduct training for child care providers and to implement special projects to further professional development statewide. One new project underway includes the development of an entry-level pre-service training curriculum for training child care providers. In addition, a set of core competencies have been developed for early care and education providers. This set of competencies, developed by a stakeholder group with statewide representation, is being incorporated into future requirements for training contractors and will be used to shape planning and policy development.

Transition from Cost Reimbursed Contracts to Fixed Priced/Outcomes Based Contracts – The Division of MCFH is incrementally moving from cost reimbursed contracts with local contractors to support MCH activities (reimbursing for and measuring outputs) to fixed priced/outcomes based contracts (fixed package price) to achieve measurable MCH outcomes. MCH contracts with local public health agencies will be the initial vehicle to support this transition and several Title V MCH performance measures have already been incorporated in the MCFH contracts.

Evidenced Based Interventions – In FFY2001, Missouri's Title V agency will also begin to better delineate Title V supported interventions that potentially impact MCH outcomes. An analysis will be conducted to determine:

One – Current MCH interventions where there is clearly a scientific or experimental evidence basis to indicate that such interventions favorably impact MCH outcomes

Two - MCFH interventions where there is a mixed scientific or experiential evidence basis to indicate that such interventions favorably impact MCH outcomes

Three – MCH interventions where there is little or no evidence basis to indicate that such interventions favorably impact MCH outcomes

Four - MCH "best practice interventions" in other states and countries that might be applied in Missouri

The results of this assessment will be used to better target Title V funding in Missouri for the greatest positive impact upon MCH outcomes.

4.3 Public Input

Public input was an essential element in the development of this application. As in previous years, the process for obtaining these comments included sharing the proposed use of funds with Missouri Department of Health management as well as with local public health agencies throughout Missouri. The proposed use of funds document was distributed to over 500 MCH stakeholders and the general public was also informed with newspaper ads placed across the state and with notices posted on the Department of Health web site. Options for comments by the public included e-mail, fax, postal mail, and telephone. As a result of these efforts, thirty-two responses were received from MCH stakeholders across the state. This year a nominal group process was also followed to help identify and select the MCH priority need areas presented in this application. A smaller group of MCH stakeholders were selected to participate in a Title V planning retreat held in March of 2000. The stakeholders selected, reviewed a draft version of the five year need assessment presented in this application, reflected upon their own experiences and applied the following criteria in delineating MCH priority need areas for Missouri:

Criterion 1: Degree to which need can be impacted by known effective interventions

Criterion 2: Degree of health-related consequences of not addressing need

Criterion 3: Degree of state and national support other than Title V for impacting need (i.e., consider the “big picture” – finances, politics, service system priorites, sociocultural issues, etc.)

Criterion 4: Degree of current demographic disparity regarding need (e.g. race, gender, income, place of residence)

Criterion 5: Degree to which other local providers or service consumers identify a particular need as a high priority

The nominal group process at this retreat, proved to be a valuable tool in identifying Missouri’s MCH priority need areas are discussed in section 3.2.1.

4.4 Technical Assistance

Please refer to Form 15 in Section 5.8 of this application.

5.1 Glossary

GLOSSARY

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year' s MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - ***(For budgetary purposes)*** Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. ***(For planning and systems development)*** Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. *[Title V, Sec. 501 (b)(2)]*

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

1) What is essential in terms of the provision of health services;
2) What is available, and
3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review

planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title XXI – The state's children's health insurance program, called MC+ for Kids in Missouri.

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the ***Federal*** Title V Block Grant allocation, the ***Applicant's*** funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the ***State*** funds (the total matching funds for the Title V allocation - match and overmatch), ***Local*** funds (total of MCH dedicated funds from local jurisdictions within the State), ***Other*** Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and ***Program Income*** (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sect. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:
(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-

(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally

prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

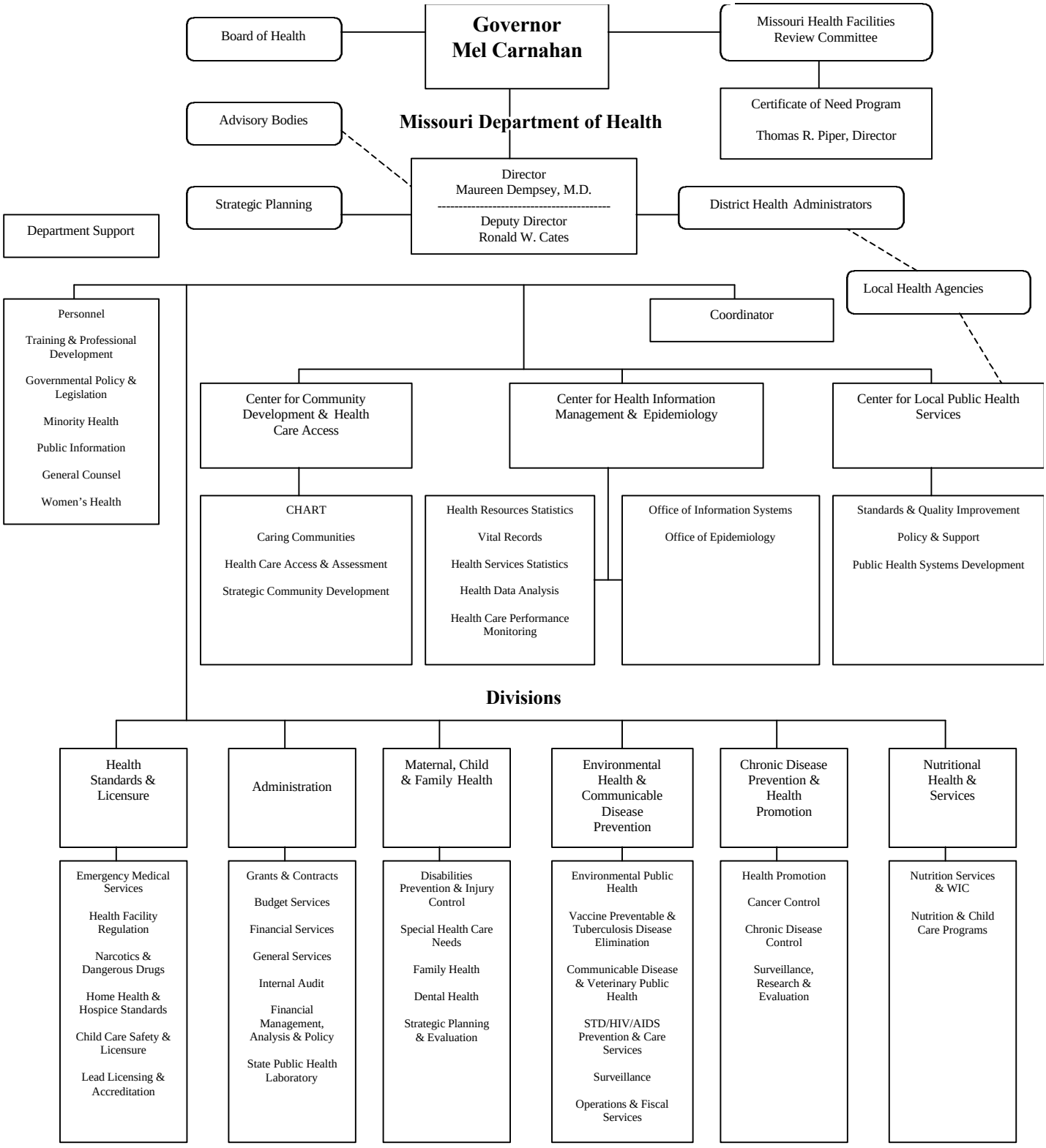
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

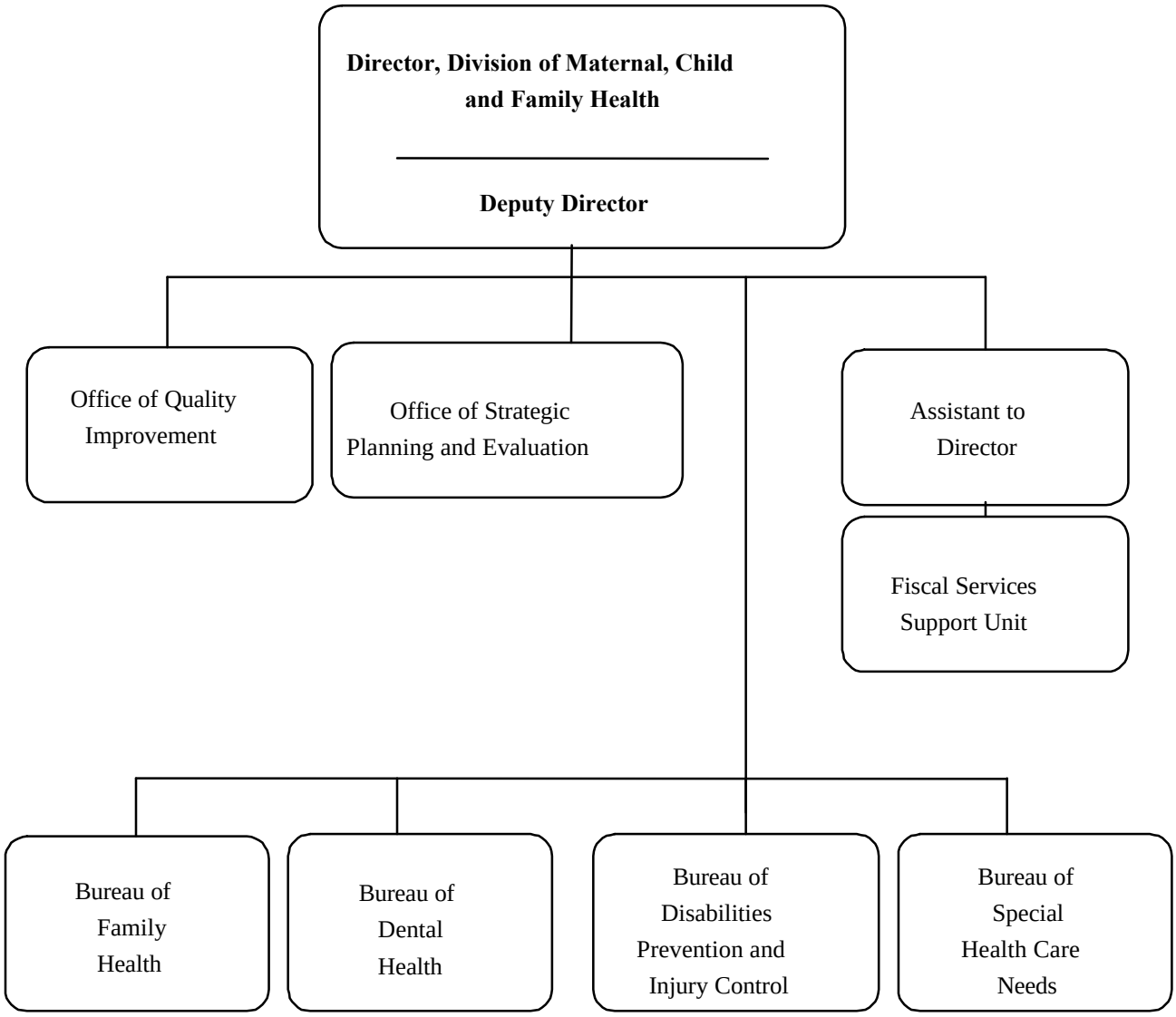
5.3 Other Supporting Documents

Missouri Department of Health

FIGURE 1



Division of Maternal, Child and Family Health
FIGURE 2



Missouri Core Public Health Services Delivered With MCHSBG Assistance By Levels of Service

FIGURE 5

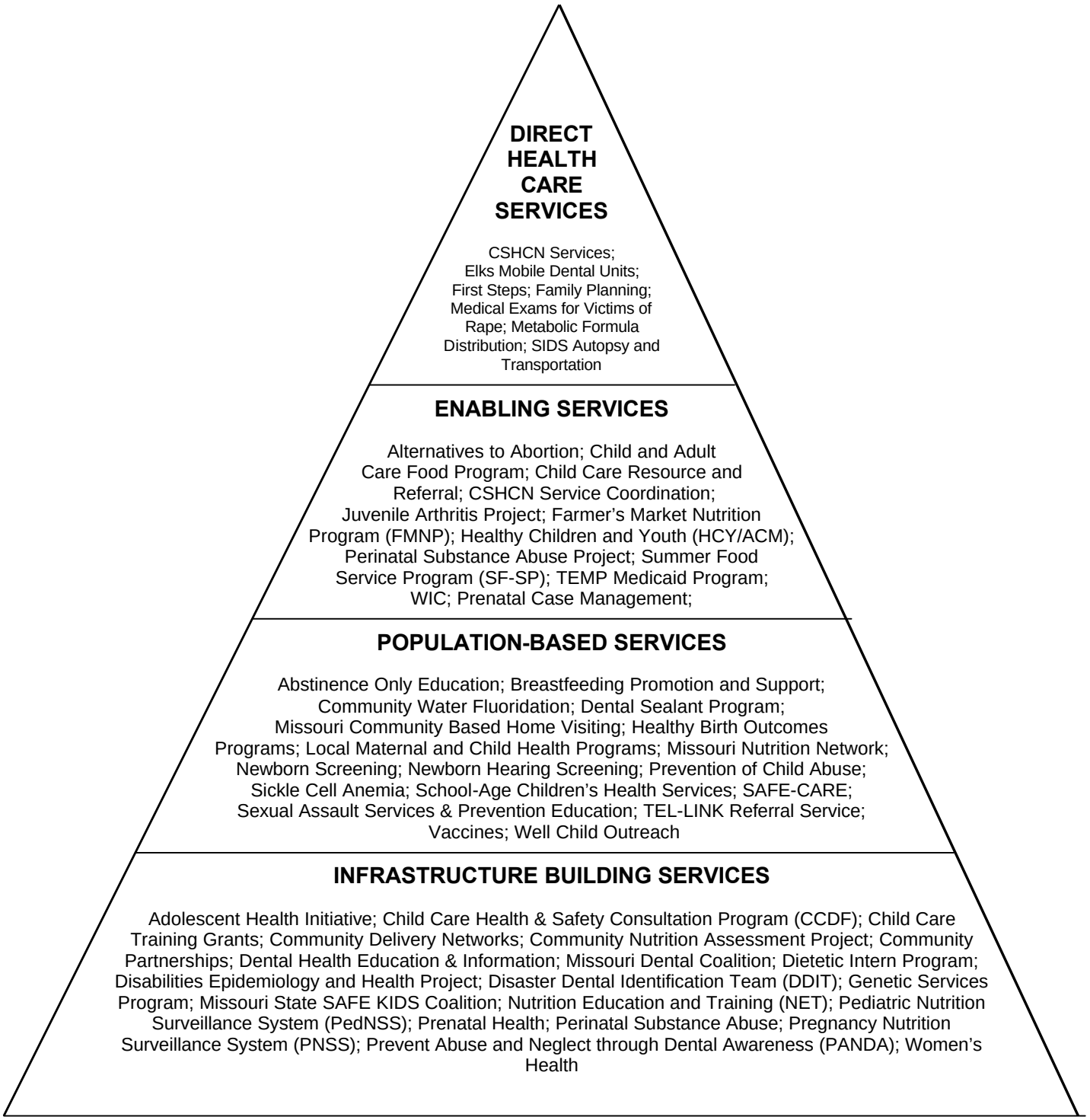


TABLE 1
PRIORITY NEEDS AND NATIONAL MEASURES

PRIORITY NEEDS	NATIONAL PERFORMANCE MEASURES																		NATIONAL OUTCOME MEASURES					
	DIRECT		ENABLING	POPULATION-BASED							INFRASTRUCTURE BUILDING													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	1	2	3	4	5	6
Healthcare Access	X	X	X				X				X	X	X	X		X	X	X	X	X	X	X	X	X
Smoking Among Children																X								
Reduce Unintended Pregnancies						X									X	X		X	X	X	X	X	X	X
Reduce Childhood Injuries								X																X
Reduce of Child Abuse and Neglect	X	X	X			X			X		X	X			X									X
Minority Health Disparities	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Expand MCH Information System	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

TABLE 2
PRIORITY NEEDS AND STATE MEASURES

PRIORITY NEEDS	STATE PERFORMANCE MEASURES									NATIONAL OUTCOME MEASURES					
	DIRECT	ENABLING		POPULATION-BASED			INFRASTRUCTURE BUILDING								
		1	2	3	4	5	6	7	8	1	2	3	4	5	6
Healthcare Access			X												
Smoking Among Children						X			X						
Reduce Unintended Pregnancies			X			X				X	X	X	X	X	X
Reduce Childhood Injuries									X						X
Reduce of Child Abuse and Neglect				X					X						X
Minority Health Disparities			X	X			X			X	X	X	X	X	X
Expand MCH Information System			X	X	X	X	X	X	X	X	X	X	X	X	X

Figure 3

Missouri Population Estimates for 1998

County	Sex	Under 1	1-4	5-14	15-17	18-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85 & Up	Total
State Total	**M**	**38496**	**147895**	**405934**	**128845**	**81273**	**173964**	**362174**	**434159**	**330805**	**227026**	**175305**	**100389**	**27035**	**2633300**
State Total	**F**	**36746**	**140734**	**386419**	**121547**	**79332**	**174141**	**374389**	**448998**	**351190**	**249105**	**215154**	**156410**	**71094**	**2805259**
State Total	**Total**	**75242**	**288629**	**792353**	**250392**	**160605**	**348105**	**736563**	**883157**	**681995**	**476131**	**390459**	**256799**	**98129**	**5438559**
Adair	M	171	420	1404	522	1061	1787	1344	1613	1195	730	639	443	124	**11453**
Adair	F	148	524	1362	432	1458	1922	1353	1653	1233	894	814	695	345	**12833**
Adair	Total	319	944	2766	954	2519	3709	2697	3266	2428	1624	1453	1138	469	**24286**
Andrew	M	86	372	1303	375	183	390	888	1360	1001	680	522	356	116	**7632**
Andrew	F	86	413	1172	379	190	403	955	1259	1014	681	628	462	288	**7930**
Andrew	Total	172	785	2475	754	373	793	1843	2619	2015	1361	1150	818	404	**15562**
Atchison	M	25	159	481	173	177	258	359	515	411	306	315	198	70	**3447**
Atchison	F	43	110	432	165	110	223	351	509	398	370	367	300	174	**3552**
Atchison	Total	68	269	913	338	287	481	710	1024	809	676	682	498	244	**6999**
Audrain	M	171	579	1819	596	284	515	1285	1808	1381	1062	1065	662	182	**11409**
Audrain	F	187	513	1740	589	223	540	1292	1848	1514	1225	1230	861	402	**12164**
Audrain	Total	358	1092	3559	1185	507	1055	2577	3656	2895	2287	2295	1523	584	**23573**
Barry	M	222	838	2533	886	410	836	1904	2333	2240	1734	1378	776	210	**16300**
Barry	F	226	763	2345	761	403	832	1887	2373	2379	1899	1415	1081	456	**16820**
Barry	Total	448	1601	4878	1647	813	1668	3791	4706	4619	3633	2793	1857	666	**33120**
Barton	M	92	318	1022	279	140	289	745	902	692	536	450	311	113	**5889**
Barton	F	87	291	935	271	111	285	752	885	731	646	522	451	222	**6189**
Barton	Total	179	609	1957	550	251	574	1497	1787	1423	1182	972	762	335	**12078**
Bates	M	102	388	1290	376	187	325	847	1190	973	817	610	437	127	**7669**
Bates	F	97	387	1166	361	156	385	868	1129	1030	899	699	605	319	**8101**
Bates	Total	199	775	2456	737	343	710	1715	2319	2003	1716	1309	1042	446	**15770**
Benton	M	80	328	1092	396	188	349	748	1080	1200	1213	1033	561	124	**8392**
Benton	F	73	301	958	416	147	310	754	1166	1328	1259	1024	646	266	**8648**
Benton	Total	153	629	2050	812	335	659	1502	2246	2528	2472	2057	1207	390	**17040**
Bollinger	M	69	307	888	286	177	315	664	885	761	590	417	287	64	**5710**
Bollinger	F	51	334	863	306	142	293	661	877	769	602	462	311	132	**5803**
Bollinger	Total	120	641	1751	592	319	608	1325	1762	1530	1192	879	598	196	**11513**
Boone	M	844	3603	8384	2391	3642	8879	10021	10498	6215	3629	2678	1470	411	**62665**
Boone	F	865	3466	8130	2085	4657	8920	10506	10531	6783	3857	3176	2348	1109	**66433**
Boone	Total	1709	7069	16514	4476	8299	17799	20527	21029	12998	7486	5854	3818	1520	**129098**
Buchanan	M	604	2210	6179	1979	1172	2471	5170	6158	4552	3486	2823	1628	518	**38950**
Buchanan	F	567	2153	5797	1823	1218	2643	5395	6369	5018	3942	3543	2908	1450	**42826**
Buchanan	Total	1171	4363	11976	3802	2390	5114	10565	12527	9570	7428	6366	4536	1968	**81776**
Butler	M	299	939	3041	1134	564	1014	2228	2956	2491	1958	1599	1006	203	**19432**
Butler	F	248	962	2869	975	510	1120	2478	3227	2712	2261	1931	1311	525	**21129**
Butler	Total	547	1901	5910	2109	1074	2134	4706	6183	5203	4219	3530	2317	728	**40561**
Caldwell	M	54	234	652	229	123	188	467	659	564	441	338	225	71	**4245**
Caldwell	F	48	252	687	224	83	215	485	639	607	422	393	341	197	**4593**
Caldwell	Total	102	486	1339	453	206	403	952	1298	1171	863	731	566	268	**8838**
Callaway	M	229	1065	2845	915	613	1165	2559	3271	2290	1529	992	651	196	**18320**
Callaway	F	227	991	2668	796	820	1448	2637	3167	2309	1571	1179	930	374	**19117**
Callaway	Total	456	2056	5513	1711	1433	2613	5196	6438	4599	3100	2171	1581	570	**37437**
Camden	M	183	794	2160	732	357	680	1721	2442	2442	2377	2167	824	134	**17013**
Camden	F	154	637	1957	647	288	665	1750	2594	2582	2460	1952	923	330	**16939**
Camden	Total	337	1431	4117	1379	645	1345	3471	5036	5024	4837	4119	1747	464	**33952**
Cape Girardeau	M	395	1728	4556	1476	1362	3054	4167	5224	3758	2530	2095	1303	361	**32009**

County	Sex	Under 1	1-4	5-14	15-17	18-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85 & Up	Total
Cape Girardeau	F	381	1616	4289	1387	1623	3138	4253	5341	4027	2770	2596	2010	874	**34305**
Cape Girardeau	Total	776	3344	8845	2863	2985	6192	8420	10565	7785	5300	4691	3313	1235	**66314**
Carroll	M	66	234	769	273	109	207	526	735	630	482	441	326	102	**4900**
Carroll	F	64	240	765	270	113	243	519	719	650	524	519	446	245	**5317**
Carroll	Total	130	474	1534	543	222	450	1045	1454	1280	1006	960	772	347	**10217**
Carter	M	42	178	524	190	88	156	332	452	433	339	239	158	47	**3178**
Carter	F	47	156	478	152	77	171	349	478	452	349	244	181	75	**3209**
Carter	Total	89	334	1002	342	165	327	681	930	885	688	483	339	122	**6387**
Cass	M	579	2389	6652	2189	1116	2089	5279	6642	5516	3268	2107	1191	364	**39381**
Cass	F	595	2292	6352	2019	1027	2162	5646	6969	5556	3135	2520	1940	926	**41139**
Cass	Total	1174	4681	13004	4208	2143	4251	10925	13611	11072	6403	4627	3131	1290	**80520**
Cedar	M	76	289	888	320	163	280	613	817	827	800	661	466	108	**6308**
Cedar	F	76	293	883	310	122	272	631	934	924	811	750	632	269	**6907**
Cedar	Total	152	582	1771	630	285	552	1244	1751	1751	1611	1411	1098	377	**13215**
Chariton	M	37	218	627	222	80	191	462	598	530	425	404	288	86	**4168**
Chariton	F	39	235	662	192	71	185	442	597	539	488	416	385	202	**4453**
Chariton	Total	76	453	1289	414	151	376	904	1195	1069	913	820	673	288	**8621**
Christian	M	333	1391	4152	1351	687	1233	3179	4315	3206	1929	1393	821	185	**24175**
Christian	F	368	1252	3790	1254	608	1381	3549	4450	3151	1942	1561	1107	409	**24822**
Christian	Total	701	2643	7942	2605	1295	2614	6728	8765	6357	3871	2954	1928	594	**48997**
Clark	M	41	200	616	195	95	188	426	580	533	336	258	199	63	**3730**
Clark	F	35	178	591	176	93	185	395	584	463	361	312	239	125	**3737**
Clark	Total	76	378	1207	371	188	373	821	1164	996	697	570	438	188	**7467**
Clay	M	1339	4839	12580	3998	2386	5407	12719	15418	11612	7138	5168	2236	569	**85409**
Clay	F	1227	4653	12272	3906	2390	5750	13460	16125	12045	7610	6239	3672	1448	**90797**
Clay	Total	2566	9492	24852	7904	4776	11157	26179	31543	23657	14748	11407	5908	2017	**176206**
Clinton	M	119	538	1590	476	235	437	1140	1511	1406	857	527	361	113	**9310**
Clinton	F	125	491	1509	523	205	443	1161	1566	1400	859	613	553	312	**9760**
Clinton	Total	244	1029	3099	999	440	880	2301	3077	2806	1716	1140	914	425	**19070**
Cole	M	455	1731	5039	1560	936	2623	6401	6870	4260	2542	1874	1026	283	**35600**
Cole	F	444	1710	4750	1494	904	2044	4601	5780	3992	2745	2404	1896	943	**33707**
Cole	Total	899	3441	9789	3054	1840	4667	11002	12650	8252	5287	4278	2922	1226	**69307**
Cooper	M	97	368	1156	460	647	1212	887	1138	886	630	587	365	106	**8539**
Cooper	F	108	350	1097	347	160	336	894	1122	902	707	670	543	254	**7490**
Cooper	Total	205	718	2253	807	807	1548	1781	2260	1788	1337	1257	908	360	**16029**
Crawford	M	152	565	1812	558	304	529	1311	1592	1450	1141	798	502	153	**10867**
Crawford	F	129	553	1728	571	262	539	1375	1643	1509	1166	890	667	266	**11298**
Crawford	Total	281	1118	3540	1129	566	1068	2686	3235	2959	2307	1688	1169	419	**22165**
Dade	M	48	230	561	166	100	157	425	549	465	408	351	246	83	**3789**
Dade	F	41	186	565	212	52	170	439	521	507	447	388	373	202	**4103**
Dade	Total	89	416	1126	378	152	327	864	1070	972	855	739	619	285	**7892**
Dallas	M	100	412	1248	405	207	346	871	1079	1029	790	542	367	116	**7512**
Dallas	F	92	401	1152	415	149	356	881	1170	1024	849	604	477	163	**7733**
Dallas	Total	192	813	2400	820	356	702	1752	2249	2053	1639	1146	844	279	**15245**
Daviess	M	56	209	594	231	87	164	400	508	530	411	299	202	69	**3760**
Daviess	F	60	198	611	214	97	165	412	546	516	434	362	310	157	**4082**
Daviess	Total	116	407	1205	445	184	329	812	1054	1046	845	661	512	226	**7842**
DeKalb	M	59	226	686	234	149	703	1666	1229	712	447	320	237	87	**6755**
DeKalb	F	49	212	643	176	91	187	510	605	543	427	397	318	216	**4374**
DeKalb	Total	108	438	1329	410	240	890	2176	1834	1255	874	717	555	303	**11129**
Dent	M	101	323	1118	402	158	325	727	1032	908	717	547	378	100	**6836**
Dent	F	67	324	1042	378	169	308	793	1046	1003	727	680	518	212	**7267**
Dent	Total	168	647	2160	780	327	633	1520	2078	1911	1444	1227	896	312	**14103**
Douglas	M	72	329	951	319	153	262	620	887	876	635	519	330	117	**6070**
Douglas	F	58	334	906	310	128	285	673	901	884	680	540	440	213	**6352**

County	Sex	Under 1	1-4	5-14	15-17	18-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85 & Over	Total
Douglas	Total	130	663	1857	629	281	547	1293	1788	1760	1315	1059	770	330	**12422**
Dunklin	M	263	787	2522	904	440	822	1696	2232	2067	1433	1160	748	191	**15265**
Dunklin	F	213	788	2431	914	439	895	1913	2486	2354	1657	1598	1228	519	**17435**
Dunklin	Total	476	1575	4953	1818	879	1717	3609	4718	4421	3090	2758	1976	710	**32700**
Franklin	M	649	2738	7682	2362	1310	2826	6150	7339	5970	3846	2616	1541	428	**45457**
Franklin	F	623	2627	7102	2362	1239	2800	6106	7327	6039	3909	3103	2175	894	**46306**
Franklin	Total	1272	5365	14784	4724	2549	5626	12256	14666	12009	7755	5719	3716	1322	**91763**
Gasconade	M	92	358	1075	331	160	346	895	1081	861	742	704	448	149	**7242**
Gasconade	F	74	413	1025	339	139	364	878	1007	906	794	789	633	287	**7648**
Gasconade	Total	166	771	2100	670	299	710	1773	2088	1767	1536	1493	1081	436	**14890**
Gentry	M	31	180	529	156	71	148	388	418	460	343	300	206	77	**3307**
Gentry	F	39	160	500	149	86	145	367	412	425	371	377	351	249	**3631**
Gentry	Total	70	340	1029	305	157	293	755	830	885	714	677	557	326	**6938**
Greene	M	1600	5312	14841	4962	4736	10344	14766	18313	13174	8673	7031	4148	1041	**108941**
Greene	F	1580	4921	14101	4438	5624	10309	15077	18746	14252	9852	9073	6699	3145	**117817**
Greene	Total	3180	10233	28942	9400	10360	20653	29843	37059	27426	18525	16104	10847	4186	**226758**
Grundy	M	69	214	686	242	127	202	513	740	669	497	428	283	95	**4765**
Grundy	F	61	220	676	254	139	211	544	751	713	556	518	480	271	**5394**
Grundy	Total	130	434	1362	496	266	413	1057	1491	1382	1053	946	763	366	**10159**
Harrison	M	62	183	599	190	97	178	456	571	544	480	366	306	91	**4123**
Harrison	F	52	159	553	183	84	167	465	525	599	499	438	430	229	**4383**
Harrison	Total	114	342	1152	373	181	345	921	1096	1143	979	804	736	320	**8506**
Henry	M	137	484	1539	549	286	518	1159	1533	1388	1024	867	600	184	**10268**
Henry	F	114	541	1400	483	238	473	1177	1629	1426	1122	1033	917	411	**10964**
Henry	Total	251	1025	2939	1032	524	991	2336	3162	2814	2146	1900	1517	595	**21232**
Hickory	M	36	142	512	173	76	149	308	499	563	713	655	342	81	**4249**
Hickory	F	34	143	464	189	66	136	360	563	575	727	632	336	143	**4368**
Hickory	Total	70	285	976	362	142	285	668	1062	1138	1440	1287	678	224	**8617**
Holt	M	27	146	433	143	59	129	295	451	312	260	226	185	68	**2734**
Holt	F	25	151	383	131	54	118	298	380	323	288	271	261	137	**2820**
Holt	Total	52	297	816	274	113	247	593	831	635	548	497	446	205	**5554**
Howard	M	51	227	746	251	215	373	540	703	554	433	342	249	72	**4756**
Howard	F	51	253	675	201	190	311	561	698	586	480	398	372	209	**4985**
Howard	Total	102	480	1421	452	405	684	1101	1401	1140	913	740	621	281	**9741**
Howell	M	225	960	2737	961	475	891	1896	2619	2324	1742	1357	892	246	**17325**
Howell	F	268	789	2591	862	422	915	2054	2768	2480	1875	1655	1269	503	**18451**
Howell	Total	493	1749	5328	1823	897	1806	3950	5387	4804	3617	3012	2161	749	**35776**
Iron	M	58	275	860	296	143	243	571	749	706	558	391	255	57	**5162**
Iron	F	69	230	853	334	148	272	594	824	748	564	440	400	233	**5709**
Iron	Total	127	505	1713	630	291	515	1165	1573	1454	1122	831	655	290	**10871**
Jackson	M	5042	18926	47759	14574	8715	20300	47722	52820	37398	25749	19455	10351	2927	**311738**
Jackson	F	4922	17832	45820	14041	8588	21494	50490	55702	41763	29893	25929	18089	8685	**343248**
Jackson	Total	9964	36758	93579	28615	17303	41794	98212	108522	79161	55642	45384	28440	11612	**654986**
Jasper	M	802	2436	7364	2413	1609	3149	6208	7692	5884	4113	3380	2035	491	**47576**
Jasper	F	772	2309	7104	2354	1499	3217	6552	8097	6248	4791	4269	3342	1402	**51956**
Jasper	Total	1574	4745	14468	4767	3108	6366	12760	15789	12132	8904	7649	5377	1893	**99532**
Jefferson	M	1413	6504	16563	5073	2793	5643	14734	17138	12822	7125	4697	2290	514	**97309**
Jefferson	F	1344	5852	15947	4801	2569	5968	15038	17179	12507	7087	5421	3341	1312	**98366**
Jefferson	Total	2757	12356	32510	9874	5362	11611	29772	34317	25329	14212	10118	5631	1826	**195675**
Johnson	M	324	1473	3509	1007	1701	3617	3425	3280	2442	1530	1001	618	173	**24100**
Johnson	F	346	1334	3095	810	1899	3127	3242	3115	2486	1575	1186	859	470	**23544**
Johnson	Total	670	2807	6604	1817	3600	6744	6667	6395	4928	3105	2187	1477	643	**47644**
Knox	M	33	90	298	111	54	102	241	289	292	245	180	133	37	**2105**
Knox	F	30	97	269	113	40	92	209	304	308	251	223	208	106	**2250**
Knox	Total	63	187	567	224	94	194	450	593	600	496	403	341	143	**4355**
Laclede	M	217	867	2503	743	428	889	1914	2339	2021	1381	1065	642	165	**15174**

County	Sex	Under 1	1-4	5-14	15-17	18-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85 & Over	Total
Laclede	F	214	786	2299	752	375	873	2000	2464	2080	1475	1229	913	395	**15855**
Laclede	Total	431	1653	4802	1495	803	1762	3914	4803	4101	2856	2294	1555	560	**31029**
Lafayette	M	187	905	2584	861	521	910	1962	2466	2219	1481	1018	745	223	**16082**
Lafayette	F	200	845	2384	716	366	843	1928	2594	2149	1531	1287	1126	602	**16571**
Lafayette	Total	387	1750	4968	1577	887	1753	3890	5060	4368	3012	2305	1871	825	**32653**
Lawrence	M	264	875	2569	895	469	882	1906	2438	2169	1488	1187	818	234	**16194**
Lawrence	F	201	830	2482	853	372	814	1980	2442	2327	1574	1428	1110	515	**16928**
Lawrence	Total	465	1705	5051	1748	841	1696	3886	4880	4496	3062	2615	1928	749	**33122**
Lewis	M	73	224	716	212	256	387	547	668	658	442	355	252	97	**4887**
Lewis	F	65	194	688	237	352	419	534	673	651	480	423	378	218	**5312**
Lewis	Total	138	418	1404	449	608	806	1081	1341	1309	922	778	630	315	**10199**
Lincoln	M	260	1208	3259	965	408	956	2598	2958	2502	1527	970	583	138	**18332**
Lincoln	F	233	1157	2996	869	408	975	2598	2944	2285	1468	1103	827	361	**18224**
Lincoln	Total	493	2365	6255	1834	816	1931	5196	5902	4787	2995	2073	1410	499	**36556**
Linn	M	83	330	1027	324	149	284	736	989	774	687	560	444	128	**6515**
Linn	F	85	322	1024	312	136	288	755	977	866	766	761	639	362	**7293**
Linn	Total	168	652	2051	636	285	572	1491	1966	1640	1453	1321	1083	490	**13808**
Livingston	M	97	318	1021	320	171	329	697	988	889	640	550	372	131	**6523**
Livingston	F	87	331	1019	304	145	375	979	1175	879	730	704	563	337	**7628**
Livingston	Total	184	649	2040	624	316	704	1676	2163	1768	1370	1254	935	468	**14151**
McDonald	M	179	587	1682	525	284	557	1245	1463	1371	1021	561	354	97	**9926**
McDonald	F	193	494	1483	466	244	583	1219	1472	1464	1034	650	503	156	**9961**
McDonald	Total	372	1081	3165	991	528	1140	2464	2935	2835	2055	1211	857	253	**19887**
Macon	M	109	331	1109	398	189	365	814	1163	937	715	623	441	136	**7330**
Macon	F	102	290	1122	391	170	362	834	1187	986	780	745	616	363	**7948**
Macon	Total	211	621	2231	789	359	727	1648	2350	1923	1495	1368	1057	499	**15278**
Madison	M	82	278	882	299	161	301	648	787	663	560	461	344	102	**5568**
Madison	F	64	280	819	271	135	273	683	843	781	629	546	435	154	**5913**
Madison	Total	146	558	1701	570	296	574	1331	1630	1444	1189	1007	779	256	**11481**
Maries	M	54	210	628	236	112	224	480	585	589	471	332	223	54	**4198**
Maries	F	49	228	576	226	103	214	455	577	649	453	368	264	113	**4275**
Maries	Total	103	438	1204	462	215	438	935	1162	1238	924	700	487	167	**8473**
Marion	M	207	735	2220	737	354	702	1638	2190	1487	1153	920	582	246	**13171**
Marion	F	193	712	2234	628	356	766	1759	2213	1638	1316	1164	1044	577	**14600**
Marion	Total	400	1447	4454	1365	710	1468	3397	4403	3125	2469	2084	1626	823	**27771**
Mercer	M	25	79	294	88	44	71	200	280	246	256	204	136	48	**1971**
Mercer	F	23	63	267	91	40	52	199	263	250	280	213	204	87	**2032**
Mercer	Total	48	142	561	179	84	123	399	543	496	536	417	340	135	**4003**
Miller	M	189	592	1789	599	292	617	1294	1733	1314	1045	849	528	161	**11002**
Miller	F	155	587	1709	547	252	588	1417	1657	1403	1076	920	765	344	**11420**
Miller	Total	344	1179	3498	1146	544	1205	2711	3390	2717	2121	1769	1293	505	**22422**
Mississippi	M	116	357	1181	402	197	331	711	875	785	514	450	292	84	**6295**
Mississippi	F	102	337	1107	350	166	370	827	995	879	659	640	484	184	**7100**
Mississippi	Total	218	694	2288	752	363	701	1538	1870	1664	1173	1090	776	268	**13395**
Moniteau	M	101	302	1125	367	190	383	855	1078	815	526	444	300	96	**6582**
Moniteau	F	100	330	1006	361	141	331	777	1030	741	595	573	473	223	**6681**
Moniteau	Total	201	632	2131	728	331	714	1632	2108	1556	1121	1017	773	319	**13263**
Monroe	M	52	261	772	227	114	207	496	677	572	402	344	242	87	**4453**
Monroe	F	53	231	709	200	87	191	530	619	598	426	376	360	188	**4568**
Monroe	Total	105	492	1481	427	201	398	1026	1296	1170	828	720	602	275	**9021**
Montgomery	M	72	338	908	309	147	283	680	865	806	606	406	353	98	**5871**
Montgomery	F	63	310	942	291	113	279	710	860	837	593	525	445	235	**6203**
Montgomery	Total	135	648	1850	600	260	562	1390	1725	1643	1199	931	798	333	**12074**
Morgan	M	98	476	1235	411	207	385	894	1181	1303	1201	998	541	149	**9079**
Morgan	F	106	427	1148	364	210	398	913	1229	1360	1284	946	663	307	**9355**
Morgan	Total	204	903	2383	775	417	783	1807	2410	2663	2485	1944	1204	456	**18434**

County	Sex	Under 1	1-4	5-14	15-17	18-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85 & Over	Total
New Madrid	M	137	594	1825	598	291	553	1070	1434	1230	817	696	406	92	**9743**
New Madrid	F	125	517	1713	550	265	563	1298	1529	1278	990	921	638	240	**10627**
New Madrid	Total	262	1111	3538	1148	556	1116	2368	2963	2508	1807	1617	1044	332	**20370**
Newton	M	388	1277	3728	1273	769	1441	2906	3877	3361	2334	1585	935	245	**24119**
Newton	F	358	1277	3524	1201	710	1371	3005	3974	3554	2329	1841	1327	562	**25033**
Newton	Total	746	2554	7252	2474	1479	2812	5911	7851	6915	4663	3426	2262	807	**49152**
Nodaway	M	101	470	1396	462	747	1498	1148	1297	988	724	632	466	165	**10094**
Nodaway	F	109	423	1378	378	1051	1407	1069	1242	1061	785	739	680	361	**10683**
Nodaway	Total	210	893	2774	840	1798	2905	2217	2539	2049	1509	1371	1146	526	**20777**
Oregon	M	74	207	724	264	143	217	471	719	744	579	416	306	67	**4931**
Oregon	F	49	203	659	276	140	217	516	834	728	604	482	392	133	**5233**
Oregon	Total	123	410	1383	540	283	434	987	1553	1472	1183	898	698	200	**10164**
Osage	M	77	347	1034	360	290	463	812	977	769	552	437	265	79	**6462**
Osage	F	92	295	960	315	163	328	726	838	745	538	479	336	148	**5963**
Osage	Total	169	642	1994	675	453	791	1538	1815	1514	1090	916	601	227	**12425**
Ozark	M	52	177	695	247	110	185	471	696	681	681	538	304	93	**4930**
Ozark	F	52	164	648	255	82	197	476	704	739	653	534	338	125	**4967**
Ozark	Total	104	341	1343	502	192	382	947	1400	1420	1334	1072	642	218	**9897**
Pemiscot	M	187	685	2016	671	312	524	1097	1428	1134	831	678	440	111	**10114**
Pemiscot	F	155	651	1931	608	336	669	1268	1551	1264	1068	895	728	278	**11402**
Pemiscot	Total	342	1336	3947	1279	648	1193	2365	2979	2398	1899	1573	1168	389	**21516**
Perry	M	109	506	1491	467	219	506	1033	1412	1002	748	576	448	140	**8657**
Perry	F	104	438	1406	444	207	455	1040	1271	1020	816	695	597	260	**8753**
Perry	Total	213	944	2897	911	426	961	2073	2683	2022	1564	1271	1045	400	**17410**
Pettis	M	272	986	2896	896	491	1044	2348	2806	2158	1743	1264	830	231	**17965**
Pettis	F	277	908	2654	847	454	1050	2419	2805	2431	1904	1592	1222	541	**19104**
Pettis	Total	549	1894	5550	1743	945	2094	4767	5611	4589	3647	2856	2052	772	**37069**
Phelps	M	235	978	2677	949	1169	2405	2449	2788	2360	1581	1304	740	186	**19821**
Phelps	F	232	905	2458	800	659	1343	2341	2849	2469	1730	1465	1126	394	**18771**
Phelps	Total	467	1883	5135	1749	1828	3748	4790	5637	4829	3311	2769	1866	580	**38592**
Pike	M	113	435	1281	468	213	400	882	1160	1050	832	629	367	117	**7947**
Pike	F	108	404	1261	382	185	342	930	1203	1140	828	758	580	279	**8400**
Pike	Total	221	839	2542	850	398	742	1812	2363	2190	1660	1387	947	396	**16347**
Platte	M	500	1913	5126	1640	927	2011	5049	6714	5381	2526	1936	842	233	**34798**
Platte	F	485	1797	4923	1632	873	2163	5289	6951	4955	2443	2003	1216	540	**35270**
Platte	Total	985	3710	10049	3272	1800	4174	10338	13665	10336	4969	3939	2058	773	**70068**
Polk	M	187	611	1875	680	562	1089	1416	1788	1540	1124	943	581	188	**12584**
Polk	F	171	582	1727	493	644	1068	1444	1770	1548	1246	1040	806	407	**12946**
Polk	Total	358	1193	3602	1173	1206	2157	2860	3558	3088	2370	1983	1387	595	**25530**
Pulaski	M	317	1394	3338	802	1338	2420	3745	3343	1612	1018	815	436	125	**20703**
Pulaski	F	315	1304	3063	851	498	1312	3108	2644	1671	1131	973	646	288	**17804**
Pulaski	Total	632	2698	6401	1653	1836	3732	6853	5987	3283	2149	1788	1082	413	**38507**
Putnam	M	32	99	334	111	59	120	265	324	324	284	232	168	50	**2402**
Putnam	F	29	100	306	113	45	100	235	347	327	299	273	226	110	**2510**
Putnam	Total	61	199	640	224	104	220	500	671	651	583	505	394	160	**4912**
Ralls	M	45	201	698	235	97	200	481	777	613	397	329	196	58	**4327**
Ralls	F	41	213	705	250	99	193	524	732	597	442	331	248	111	**4486**
Ralls	Total	86	414	1403	485	196	393	1005	1509	1210	839	660	444	169	**8813**
Randolph	M	161	576	1812	532	331	879	1984	2200	1509	931	801	544	158	**12418**
Randolph	F	164	504	1714	501	318	636	1373	1760	1359	1032	909	853	483	**11606**
Randolph	Total	325	1080	3526	1033	649	1515	3357	3960	2868	1963	1710	1397	641	**24024**
Ray	M	158	634	2019	681	311	570	1423	1882	1752	1081	672	417	107	**11707**
Ray	F	149	667	1821	628	256	553	1494	1945	1713	1081	791	596	307	**12001**
Ray	Total	307	1301	3840	1309	567	1123	2917	3827	3465	2162	1463	1013	414	**23708**
Reynolds	M	50	142	516	195	85	148	360	469	490	378	254	154	36	**3277**
Reynolds	F	31	160	467	186	76	137	368	494	484	369	275	201	99	**3347**

County	Sex	Under 1	1-4	5-14	15-17	18-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85 & Over	Total
Reynolds	Total	81	302	983	381	161	285	728	963	974	747	529	355	135	**6624**
Ripley	M	92	319	1091	396	187	344	734	904	902	784	525	354	88	**6720**
Ripley	F	83	398	1086	390	171	344	755	1006	1004	832	636	480	167	**7352**
Ripley	Total	175	717	2177	786	358	688	1489	1910	1906	1616	1161	834	255	**14072**
St. Charles	M	2077	9393	22935	6572	3431	7595	21208	25655	17700	9016	6322	2656	604	**135164**
St. Charles	F	2019	8637	22228	6315	3215	8051	22243	25875	16628	8657	7216	4283	1822	**137189**
St. Charles	Total	4096	18030	45163	12887	6646	15646	43451	51530	34328	17673	13538	6939	2426	**272353**
St. Clair	M	48	189	618	244	111	182	425	587	586	538	444	312	93	**4377**
St. Clair	F	43	210	570	212	96	175	429	619	584	633	509	414	209	**4703**
St. Clair	Total	91	399	1188	456	207	357	854	1206	1170	1171	953	726	302	**9080**
Ste. Genevieve	M	87	474	1446	459	223	455	1116	1427	1034	837	674	395	97	**8724**
Ste. Genevieve	F	103	487	1338	425	198	422	1073	1311	1139	842	683	515	243	**8779**
Ste. Genevieve	Total	190	961	2784	884	421	877	2189	2738	2173	1679	1357	910	340	**17503**
St. Francois	M	339	1330	4218	1409	825	1932	4252	4564	3400	2513	2019	1098	274	**28173**
St. Francois	F	339	1279	3816	1371	727	1444	3300	4081	3483	2717	2406	1684	697	**27344**
St. Francois	Total	678	2609	8034	2780	1552	3376	7552	8645	6883	5230	4425	2782	971	**55517**
St. Louis Co	M	6616	25626	69671	21807	12462	28260	65466	82719	62642	42825	35178	17998	4365	**475635**
St. Louis Co	F	6227	24724	66583	21059	11838	29117	70501	90753	69160	47264	43444	29395	12996	**523061**
St. Louis Co	Total	12843	50350	136254	42866	24300	57377	135967	173472	131802	90089	78622	47393	17361	**998696**
Saline	M	156	488	1722	587	409	819	1328	1762	1301	943	807	528	171	**11021**
Saline	F	151	534	1622	525	334	706	1322	1685	1391	1060	1013	885	454	**11682**
Saline	Total	307	1022	3344	1112	743	1525	2650	3447	2692	2003	1820	1413	625	**22703**
Schuyler	M	27	132	310	121	53	99	244	316	303	214	170	132	42	**2163**
Schuyler	F	21	121	308	98	59	100	249	310	290	234	204	200	86	**2280**
Schuyler	Total	48	253	618	219	112	199	493	626	593	448	374	332	128	**4443**
Scotland	M	35	146	361	129	51	107	247	331	305	236	196	138	51	**2333**
Scotland	F	43	110	322	104	51	116	274	310	326	253	224	227	121	**2481**
Scotland	Total	78	256	683	233	102	223	521	641	631	489	420	365	172	**4814**
Scott	M	318	1154	3410	1063	601	1099	2336	3118	2439	1490	1200	760	176	**19164**
Scott	F	281	1104	3163	1103	559	1164	2643	3389	2639	1744	1695	1226	388	**21098**
Scott	Total	599	2258	6573	2166	1160	2263	4979	6507	5078	3234	2895	1986	564	**40262**
Shannon	M	53	224	647	229	98	215	485	608	564	409	282	186	50	**4050**
Shannon	F	52	235	592	200	93	205	500	649	586	441	337	223	89	**4202**
Shannon	Total	105	459	1239	429	191	420	985	1257	1150	850	619	409	139	**8252**
Shelby	M	31	177	531	163	65	133	362	488	412	309	253	214	82	**3220**
Shelby	F	31	191	489	187	52	148	382	438	449	340	342	335	198	**3582**
Shelby	Total	62	368	1020	350	117	281	744	926	861	649	595	549	280	**6802**
Stoddard	M	183	673	2139	852	438	797	1614	2213	2008	1358	1075	745	184	**14279**
Stoddard	F	164	658	2055	688	416	772	1722	2331	2100	1563	1381	1070	424	**15344**
Stoddard	Total	347	1331	4194	1540	854	1569	3336	4544	4108	2921	2456	1815	608	**29623**
Stone	M	150	537	1677	593	328	609	1261	1842	1901	1900	1463	726	164	**13151**
Stone	F	161	483	1627	641	261	568	1340	1960	2129	1934	1496	798	258	**13656**
Stone	Total	311	1020	3304	1234	589	1177	2601	3802	4030	3834	2959	1524	422	**26807**
Sullivan	M	60	128	491	173	96	175	369	504	492	378	279	208	63	**3416**
Sullivan	F	43	136	454	171	76	190	331	521	508	418	325	299	152	**3624**
Sullivan	Total	103	264	945	344	172	365	700	1025	1000	796	604	507	215	**7040**
Taney	M	258	697	2170	787	571	1011	1747	2368	2302	2075	1638	980	239	**16843**
Taney	F	260	563	2080	585	559	1072	1861	2595	2487	2329	1732	1147	391	**17661**
Taney	Total	518	1260	4250	1372	1130	2083	3608	4963	4789	4404	3370	2127	630	**34504**
Texas	M	151	555	1760	597	268	492	1176	1611	1440	1175	899	577	147	**10848**
Texas	F	130	529	1696	533	267	519	1228	1703	1513	1196	1065	778	352	**11509**
Texas	Total	281	1084	3456	1130	535	1011	2404	3314	2953	2371	1964	1355	499	**22357**
Vernon	M	141	499	1484	499	244	451	1069	1469	1166	899	704	445	107	**9177**
Vernon	F	129	469	1482	426	449	559	1106	1560	1247	999	854	659	320	**10259**

County	Sex	Under 1	1-4	5-14	15-17	18-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85 & Over	Total
Vernon	Total	270	968	2966	925	693	1010	2175	3029	2413	1898	1558	1104	427	**19436**
Warren	M	173	771	1954	567	324	608	1641	1968	1647	1077	868	503	133	**12234**
Warren	F	150	779	1956	548	253	644	1618	1919	1632	1091	908	630	238	**12366**
Warren	Total	323	1550	3910	1115	577	1252	3259	3887	3279	2168	1776	1133	371	**24600**
Washington	M	160	644	2030	721	364	740	1733	1901	1531	995	651	375	85	**11930**
Washington	F	170	588	1794	635	330	628	1368	1734	1418	964	732	479	196	**11036**
Washington	Total	330	1232	3824	1356	694	1368	3101	3635	2949	1959	1383	854	281	**22966**
Wayne	M	74	308	896	326	173	312	651	786	887	829	598	463	96	**6399**
Wayne	F	59	287	829	306	161	315	665	850	998	799	728	492	171	**6660**
Wayne	Total	133	595	1725	632	334	627	1316	1636	1885	1628	1326	955	267	**13059**
Webster	M	242	811	2488	808	430	894	1926	2347	2006	1221	876	543	147	**14739**
Webster	F	211	750	2312	718	354	812	1738	2276	1956	1223	954	767	298	**14369**
Webster	Total	453	1561	4800	1526	784	1706	3664	4623	3962	2444	1830	1310	445	**29108**
Worth	M	14	55	176	53	25	47	109	135	147	125	100	82	28	**1096**
Worth	F	9	51	160	48	15	39	105	141	165	149	110	125	82	**1199**
Worth	Total	23	106	336	101	40	86	214	276	312	274	210	207	110	**2295**
Wright	M	142	529	1700	537	248	482	1101	1333	1257	961	684	425	135	**9534**
Wright	F	117	532	1546	497	209	497	1148	1437	1300	1044	791	634	292	**10044**
Wright	Total	259	1061	3246	1034	457	979	2249	2770	2557	2005	1475	1059	427	**19578**
St. Louis City	M	2897	10145	25558	7712	4684	11366	24785	24076	15210	12223	9054	6042	1762	**155514**
St. Louis City	F	2687	10023	24824	7329	5037	12898	27436	26052	18920	16632	14379	11827	5758	**183802**
St. Louis City	Total	5584	20168	50382	15041	9721	24264	52221	50128	34130	28855	23433	17869	7520	**339316**

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National "Core" Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets